ARKANSAS'S MEDICAID WORK REQUIREMENT: A REGULATORY AND ETHICAL ANALYSIS

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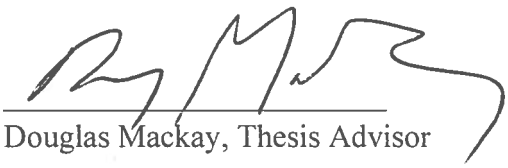

Douglas Mackay, Thesis Advisor

Luc Bovens, Second Reader

For my mom, the source of my commitment to public service–
Lori Rubin.

Contents

Abstract

On June 1, 2018, Arkansas became the first state in the nation to implement a Work and Community Engagement requirement in order to eligible for Medicaid. Under Arkansas's new Medicaid plan, non-pregnant adult recipients who are under the age of fifty years old must engage in at least 80 hours of WCE activities every month. In order to continue receiving benefits, recipients must also report their hours at the end of every month through the state's web-based platform Access Arkansas. Failing to report their WCE hours for three consecutive or non-consecutive months in a given calendar year results in loss of Medicaid coverage for the rest of the calendar year. This paper sets out to answer whether a work requirement for Medicaid is legally permissible and whether the requirement ought to be allowed regardless of its legal standing. Given the program has disenrolled over 18,000 individuals from the state's Medicaid rolls within the first nine months of implementation, I ultimately find that Arkansas's Medicaid work requirement fails to adhere to federal regulation and constitutes an instance of impermissible Welfare State Paternalism. This conclusion bears heavy consequences for the multiple other states who are currently rolling out similar work requirements or are awaiting federal approval to do so. In order to better understand the mechanisms underlying the reduction in Arkansas' Medicaid coverage population, future research ought to utilize recipient surveys regarding barriers to entry and how recipients respond to different incentives to work. Ethically speaking, policymakers on the state and national level ought to revisit the question of whether healthcare is a right and what this tangibly implies for the roles and responsibilities of government to assure this right.

- EXTEROVICH-RUBIN

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I. Introduction

When President Johnson signed Medicaid into law on July 30, 1965, the US government acknowledged both an existent right to healthcare for low-income citizens and a duty of the US government to provide it. As a federal program, Medicaid's mandate is to provide health insurance coverage to low-income Americans who cannot afford such insurance otherwise. Housed in the federal Centers for Medicare and Medicaid Services (CMS), Medicaid is jointly funded by states and the federal government. States have never been required by law to opt in to Medicaid, but all fifty states currently offer a version of the program. States have maintained significant autonomy over the structure and implementation of their respective Medicaid programs, but every state covers some low-income individuals, pregnant women, the elderly, families and children, and those with disabilities.[1] As a means of protecting states' abilities to innovate and customize their respective Medicaid programs, Congress included Section 1115 in the Social Security Act, which originally authorized Medicaid. Section 1115 of the Social Security Act,

> "gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP) programs. Under this authority, the Secretary may waive certain provisions of the Medicaid law to give states additional flexibility to design and improve their programs."[2]

This section was included to allow states to run pilot programs and experiment with programmatic innovations that could improve the effectiveness of the program. States have most often taken advantage of this flexibility to increase or decrease the income cutoff for eligibility to the program

[1] "Program History," Medicaid, accessed November 15, 2018. https://www.medicaid.gov/about-us/program-history/index.html
[2] "Section 1115 Demonstrations, Medicaid, accessed January 3, 2019. https://www.medicaid.gov/medicaid/section-1115-demo/index.html

or to foster incentives for recipients to take more responsibility over their health. As I will discuss in more depth below, however, state governments have recently begun taking advantage of Section 1115 Waivers to require that beneficiaries participate in "work and community engagement" (WCE) activities in order to access their benefits. On June 1, 2018, Arkansas became the first state to implement a Medicaid WCE requirement. Going forward, this paper will focus on Arkansas's WCE requirement along with its legal and ethical implications.

Under Arkansas's new Medicaid plan, non-pregnant adult recipients who are under the age of fifty years old must engage in at least 80 hours of WCE activities every month.[3] In order to continue receiving benefits, recipients must also report their hours at the end of every month through the state's web-based platform Access Arkansas.[4] If recipients fail to report their WCE hours for three consecutive or non-consecutive months in a given calendar year, they lose their Medicaid coverage for the rest of the calendar year.[5] Unless they receive a "good cause exemption" upon appeal, they must wait to re-apply for coverage until the following November 1 for coverage beginning the following January.[6] In the first three months of Arkansas' pilot project, more than 4,300 people were removed from the program for the rest of the year.[7] Many current Medicaid enrollees report not being aware of the new requirement, but even with the relevant knowledge, many non-elderly, non-pregnant enrollees may not be able to meet the new requirement due to extenuating health circumstances or barriers to transportation and internet access

[3] Henry J Kaiser Family Foundation. (2018, September 28). *Approved and Pending Eligibility and Enrollment Restrictions.* Retrieved from: http://files.kff.org/attachment/Approved-and-Pending-Eligibility-and-Enrollment-Restrictions

[4] Margot Sanger-Katz, "One Big Problem With Medicaid Work Requirement: People Are Unaware It Exists," *New York Times*, September 24, 2018. https://www.nytimes.com/2018/09/24/upshot/one-big-problem-with-medicaid-work-requirement-people-are-unaware-it-exists.html

[5] *Ibid.*

[6] J. Craig Wilson and Joseph Thompson, "Nation's First Medicaid Work Requirement Sheds Thousands From Rolls In Arkansas," *Health Affairs,* October 2, 2018. https://www.healthaffairs.org/do/10.1377/hblog20181001.233969/full/

[7] Margot Sanger-Katz, "One Big Problem With Medicaid Work Requirement: People Are Unaware It Exists," *New York Times*, September 24, 2018. https://www.nytimes.com/2018/09/24/upshot/one-big-problem-with-medicaid-work-requirement-people-are-unaware-it-exists.html

(Wagner, 2019). As of January 1, Kentucky and Indiana joined Arkansas in implementing a Medicaid WCE requirement. I will discuss this further below.

While the stated goal of Arkansas' WCE requirement is to promote the health of Medicaid recipients, it is not clear whether the scope of HHS's authority, as endowed by Congress, legally allows CMS to attach such a requirement to Medicaid. This regulatory question encompasses two concerns: (1) whether a Medicaid WCE requirement constitutes an overreach of the program's mandate, and (2) whether a Medicaid WCE requirement fundamentally undermines the program's mandate. Addressing these two concerns is necessary to determine if the WCE requirement is permissible within the US legal and regulatory framework.

Equally important as this regulatory question is whether this policy is normatively permissible. That is, there is a meaningful philosophical question as to whether this policy commits a moral wrong that is so severe as to render it ethically unjustifiable.

Hinging the health care benefits for low-income adults on whether they are working, volunteering, or actively seeking a job for a minimum number of required hours raises fundamental ethical concerns of paternalism and government overreach. With these two concerns in mind, one regulatory and one normative, this study aims to answer two corresponding questions:

(1) Is a Medicaid WCE requirement legally permissible under existing regulation?
   a. Is it within the scope of CMS's authority to permit states to attach a work and community engagement requirement to Medicaid benefits?
   b. Does Arkansas's WCE requirement adequately support Medicaid's fundamental objectives of "furnishing" healthcare coverage and necessary rehabilitation services to needy individuals?

(2) Is it normatively permissible for states to attach a work requirement condition to government subsidized health care for low-income adults?

The research problem of Medicaid WCE requirements is significant in that eight states have had work requirements approved and seven more have waiver applications pending approval from CMS.[8] Arkansas's WCE requirement may become a bellwether for attaching similar requirements to other welfare benefits, such as housing. My consideration of these two research questions will inform Medicaid policy-making, and welfare policy-making more broadly, by bringing to light whether pursuing a work requirement for Medicaid eligibility is both regulatorily sound and ethically permissible, and consequently, whether this policy should be pursued in Arkansas and elsewhere.

A. Evolution of Medicaid

1980 - 2010: Gradual Expansion

Originally, Medicaid "was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children.[9]" State Medicaid programs have, however, periodically revised eligibility to account for rising numbers of uninsured Americans. Beginning in the 1980s and until 2010, the percentage of uninsured poor Americans steadily increased alongside rising healthcare costs.[10] To accommodate these rising healthcare costs, states continually tinkered with both expenditures per poor person and enrollment per poor person.[11] Among the states who rapidly grew their Medicaid programs between 1992 and 2009, some (like Hawaii, Oklahoma, and Vermont) increased both spending and enrollment per poor person while other states, such as Minnesota and New Mexico, remarkably increased only spending.[12] Still others lead the country in their

[8] "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State," Henry J Kaiser Family Foundation, last modified March 15, 2019, https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table2
[9] National Federation of Independent Business et al. v. Sebelius, 55
[10] Katherine R. Levit, Gary L. Olin, and Suzanne W. Letsch, "Americans' Health Insurance Coverage, 1980-91," *Health Care Financing Review* 14, no. 1 (Fall 1992): 34.
[11] Joel C. Cantor, Frank J. Thompson, Jennifer Farnham, "States' Commitment to Medicaid Before the Affordable Care Act: Trends and Implications," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* (Spring 2013): 74.
[12] *Ibid.*

increases in per poor person enrollment. Louisiana and New Hampshire were among this final group.[13] On the other end of the spectrum, Colorado had among the slowest growing Medicaid programs in both spending and enrollment per poor person.[14] Meanwhile, "Indiana, Nevada, New Jersey, and Rhode Island ranked last in expenditure growth rates, while Kansas, Ohio, Utah, and Virginia achieved this distinction in terms of enrollment per poor person."[15] As one might expect, the degree of variety among states' Medicaid spending and enrollment resulted in a patchwork of health care coverage.

Affordable Care Act

In 2010, however, the federal government abandoned the incremental approach to expanding healthcare coverage by passing a policy that dramatically increased access to healthcare for low-income Americans: The Affordable Care Act (ACA). As part of the ACA's mandate, every state was initially required to expand Medicaid coverage to all adults under 65 with an income under 133% of the federal poverty line.[16] Many criticized the ACA as a form of government overreach, an act that compromised "Americans' fundamental freedoms."[17] When the expansion was challenged in the 2012 U.S. Supreme Court case *National Federation of Independent Business Et Al. v. Sebelius,* then HHS Secretary Kathleen Sebelius argued that the ACA's Medicaid expansion did not fundamentally change Medicaid's purpose or goals. Rather, she argued that it simply enlarged the pool of needy individuals who would be eligible for Medicaid benefits. The Court, however, held in a 5-4 decision that the Act's "Medicaid expansion … accomplishe[d] a shift in kind, not merely degree."[18] Justice Roberts noted that "previous amendments to Medicaid merely altered and expanded the boundaries of these [four original] categories," whereas the

[13] *Ibid.*
[14] *Ibid.*
[15] *Ibid.*
[16] Molly Frean, Jonathan Gruber, and Benjamin D. Sommers, "Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act," *Journal of Health Economics* 53 (2017): 73.
[17] Robert Moffit, "Individual Mandate Unconstitutional, Unenforceable," The Heritage Foundation, March 23, 2011. https://www.heritage.org/health-care-reform/commentary/individual-mandate-unconstitutional-unenforceable
[18] *National Federation of Independent Business Et. Al. v. Sebelius*, 567 U.S. 519 (2012): 55.

ACA "transformed" Medicaid such that "it is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage."[19]

While the Court ultimately overturned the requirement for states to enact a universal expansion of Medicaid, it did not challenge the so-called "in kind" shift of the program's objectives. As such, the decision left in its wake a mix of states that expanded coverage and those that did not. What remained constant within the ACA's Medicaid expansion debate, however, was that Medicaid's objective remained strictly centered around health insurance as the vehicle through which the government was to improve the health and wellness of low-income Americans.

A New Focus for CMS: Workforce Participation

This traditional focus of Medicaid changed in January of 2018, when CMS declared an interest in "incentivizing work and community engagement" among non-elderly, non-pregnant adult recipients as a mechanism to improve their health and wellness.[20] While states have continually relied on Section 1115 to experiment with pilot programs and program innovations, this policy change marked the first time that health and wellness were formally attached to the notion of economic productivity. This policy change also marked the first time that CMS would allow states to use the Section 1115 waiver for the express purpose of attaching a work and community engagement (WCE) requirement to Medicaid eligibility. In his letter to all fifty State Medicaid Directors, then-administrator for CMS, Brian Neale, justified the Center's decision to support Medicaid WCE requirements by stating that "CMS recognizes that … targeting certain health determinants, including productive work and community engagement, may improve health outcomes."[21] One day after this letter was released, CMS approved Kentucky's proposed

[19] Sarah Rosenbaum, "The Supreme Court's Medicaid Ruling: 'A Shift In Kind, Not Merely Degree'," *Health Affairs Blog,* June 28, 2012. https://www.healthaffairs.org/do/10.1377/hblog20120628.020808/full/
[20] Brian Neale, "RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," letter to State Medicaid Directors, January 11, 2018.
[21] *Ibid.*, 2.

Medicaid WCE requirements.[22] Indiana, Arkansas, and New Hampshire followed suit shortly after, each receiving federal approval for their respective Medicaid WCE requirements.[232425]

Before Kentucky was able to implement its WCE requirement plan, however, United States District Judge James E. Boasberg ultimately struck down the state's policy change due to a "glaring" oversight on behalf of Health and Human Services (HHS) Secretary Alexander Azar: "The record shows that 95,000 people would lose Medicaid coverage, and yet the Secretary paid no attention to that deprivation."[26] This legal objection has not yet impeded other states from pursuing their respective plans, as there are now eight states with approved WCE waivers, and seven that are still pending approval as of March 15, 2019.[27] After the Trump administration approved an amended version of Kentucky's WCE requirement, Judge Boasberg has since taken up a new class action challenge against Kentucky's requirement as well as a class action suit filed in August 2018 against Arkansas's WCE requirement.[28]

In the next chapter, I will discuss how Arkansas's Medicaid program has evolved since 2013. This will allow us to situate the Arkansas Works WCE requirement within the context of Arkansas's unique history with Medicaid.

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[22] Commonwealth of Kentucky, "Gov. Matt Bevin Announces Approval of Kentucky HEALTH," January 12, 2018. https://kentucky.gov/Pages/Activity-stream.aspx?n=KentuckyGovernor&prId=573

[23] Centers for Medicare and Medicaid Services, *Expenditure Authority No. l l-W-00296/5: "Healthy Indiana Plan (HIP), "*by Demetrios Kouzoukas https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf

[24] Centers for Medicare and Medicaid Services, *Expenditure Authority No. 11-W-00287/6: Arkansas Works Section 1115 Demonstration*, by Seema Verma

[25] Dave Solomon, "New Hampshire Gets Its Medicaid Work Requirement," *Governing (Tribune News Service),* May 9, 2018. https://www.governing.com/topics/health-human-services/gov-new-hampshire-expanded-medicaid.html

[26] Abby Goodnough, "Judge Strikes Down Kentucky's Medicaid Work Rules," *New York Times,* June 29, 2018. https://www.nytimes.com/2018/06/29/health/kentucky-medicaid-work-rules.html

[27] "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State," Henry J Kaiser Family Foundation, last modified March 15, 2019, https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table2

[28] Benjamin Hardy, "Trump Administration Defends Arkansas's Medicaid Work Requirements," *Arkansas Times*, December 1, 2018. https://www.arktimes.com/ArkansasBlog/archives/2018/12/01/trump-administration-defends-arkansass-work-requirements-for-medicaid

In Chapter 3, I introduce the conceptual frameworks for understanding the precursor to Medicaid's work requirement, the Temporary Assistance to Needy Families (TANF). Since Medicaid requirements have only recently been pursued as a policy option, I draw normative lessons and empirical data from TANF to inform my analysis of Arkansas's WCE requirement. I also discuss the theories that bear on whether work requirements are likely to bring about the desired behaviors.

Chapter 4 focuses on whether the policy properly follows from existing regulations and whether it is within the authority of the HHS Secretary and CMS Administrator to encourage workforce participation. I draw legal precedent and regulatory interpretation from the Federal Court's decision in the class action suit, *Stewart et al. v Azar et al.*, which challenged Kentucky's Medicaid WCE requirement. Borrowing from Judge Boasberg's interpretation of Medicaid's core functions, I ultimately conclude that the work requirement fails to be regulatorily permissible because it fails to promote healthcare coverage among low income individuals, one of the two fundamental objectives of Medicaid.

In Chapter 5, I evaluate the policy on normative grounds through Douglas Mackay's framework of Welfare State Paternalism.[29] Within this framework, there are multiple factors that bear on the extent to which a paternalistic welfare policy is pro tanto wrong. By considering each in the context of the Arkansas Works WCE requirement, I offer a reasoned judgement of the requirement's degree of wrongness and whether its "reasonably expected net benefit outweighs its pro tanto wrongness."[30] Ultimately, I conclude that the policy fails to bring about the remarkable health benefits that would be necessary to justify the wrong wrought by the requirement. In fact, preliminary data seems to suggest that the requirement has considerably *decreased* quality of life among beneficiaries. These findings bear significant implications not only for the fate of the Arkansas Works's WCE requirement, but also for the conditionality of welfare benefits going forward.

[29] Douglas Mackay, "Basic Income, Cash Transfers, and Welfare State Paternalism," *The Journal of Political Philosophy* 0, no. 0 (2019).
[30] *Ibid,* 25.

I discuss these considerations in Chapter 6, along with policy recommendations and conclusions, in which I discuss my recommendations for how DHS and the State of Arkansas should move forward. Particularly, I recommend that Arkansas should cease implementation of the Arkansas Works requirement and conduct extensive outreach, both to inform beneficiaries of their reinstated coverage and to survey beneficiaries on how, and in what ways, the work requirement impacted their mental and physical health and wellbeing. I also recommend that CMS calls for a pause in all state WCE requirements until (1) such surveys from Arkansan beneficiaries are thoroughly reviewed and (2) measures are put in place by each state to ensure that healthcare coverage is not compromised by a WCE requirement.

II. Medicaid In Arkansas

Seven years ago, Arkansas had one of the lowest rates of insured citizens out of any state.[31] Six years ago, the state made history by being the first state to expand Medicaid under the ACA.[32] In 2018, under new, fiscally conservative political leadership on both the state and federal level, Arkansas made history again by being the first state to revoke Medicaid benefits from those who don't report enough work, school or community service hours. [33] To make sense of Arkansas's unique relationship with Medicaid, I describe in this chapter how the state's approach to Medicaid has evolved over the past 6 years. In doing so, I situate Arkansas's recent Medicaid WCE requirement within the larger policy context in which it emerged. I then delve into the details of the requirement, including how it was approved and implemented as well as the requirement's empirical consequences.

[31] Margot Sanger-Katz, "Election Results Endanger Innovative Arkansas Medicaid Plan," *New York Times,* November 6, 2014. https://www.nytimes.com/2014/11/07/upshot/elections-put-future-of-innovative-arkansas-medicaid-plan-in-doubt.html?action=click&module=RelatedCoverage&pgtype=Article&region=Footer
[32] Louise Norris, "Arkansas and the ACA's Medicaid Expansion," *Health Insurance.org,* November 25, 2018. https://www.healthinsurance.org/arkansas-medicaid/
[33] *Ibid.*

A. 2013-2016: Expanding Access and Coverage

In September 2013, Arkansas made national headlines as the first state to expand Medicaid coverage through the ACA. Since then-Governor Mike Beebe anticipated that the state legislature would stonewall "a traditional Medicaid expansion," Beebe worked with Democratic state legislators and Arkansas DHS to design a new kind of Medicaid plan. Rather than using the federal "expansion money" to furnish public coverage for the expansion population (all adult Arkansans with incomes below 138% of the federal poverty line (FPL)), the state would instead use the money to buy private health insurance plans for these newly eligible individuals.[34] This plan was first known as the "Arkansas Health Care Independence Program," later referred to as the "Private Option" for state-sponsored healthcare coverage.[35]

Arkansas's Private Option held the attention of the country as it managed to drop the state's rate of uninsured non-elderly adults from 27.5 percent to 15.6 percent within the first year of implementation– "one of the largest declines in the country."[36] In examining this impressive jump, however, it is important to note just how few Arkansans were covered by Medicaid before the state expanded. Before 2013, Arkansas maintained "one of the highest uninsured rates in the country" as well as "one of the lowest eligibility thresholds in the country."[37] Indeed, prior to its Medicaid expansion, Arkansas only covered parents who had incomes under 17 percent of the federal poverty line, or "$3,415 per year for a family of three in 2015."[38] The pre-expansion program provided no healthcare coverage for non-disabled, childless adults "regardless of how low their income was."[39] Once Arkansas allowed all adults under 138% FPL to

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[34] Margot Sanger-Katz, "Election Results Endanger Innovative Arkansas Medicaid Plan," *New York Times,* November 6, 2014. https://www.nytimes.com/2014/11/07/upshot/elections-put-future-of-innovative-arkansas-medicaid-plan-in-doubt.html?action=click&module=RelatedCoverage&pgtype=Article&region=Footer

[35] Louise Norris, "Arkansas and the ACA's Medicaid Expansion," *Health Insurance.org,* November 25, 2018. https://www.healthinsurance.org/arkansas-medicaid/

[36] Jocelyn Guyer, Naomi Shine, MaryBeth Musumeci, and Robin Rudowitz, "A Look at the Private Option in Arkansas," *Kaiser Family Foundation*, August 26, 2015. https://www.kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/view/print/

[37] *Ibid.*

[38] *Ibid.*

[39] *Ibid.*

enroll in Medicaid, the need for government-provisioned healthcare among low-income Arkansans became clear: in the first two years of implementation, the state was able to enroll 245,000 people in private health insurance plans through the Private Option.[40]

The fate of the Private Option became uncertain in 2014, however, when Arkansans elected a new governor, Asa Hutchinson, and a number of state legislators who opposed the Medicaid expansion. As put by Margot Sanger-Katz, writer for the New York Times,

> "voters replaced an enthusiastically supportive governor with one who is noncommittal. And, more critically they replaced legislators in both houses who supported the expansion with those who campaigned against it. The program is up for reauthorization this year, and local advocates say they're worried it could be eliminated."[41]

Leading up to the reauthorization vote, Hutchinson remained hesitant to share his views on whether or not to extend the program. Rather, he openly appealed to more conservative legislators by suggesting possible cost-saving measures.[42] Soon, the litmus test for the Private Option's success became less about reducing the uninsured population and more about reducing the state's spending.[43]

B. 2016-2018: Reducing Costs and Reducing Enrollment

Over the course of 2015 and early 2016, Governor Hutchinson worked with Republican legislators to design and ultimately implement "an overhaul of Medicaid expansion"[44] called "Arkansas Works." The state legislature "approved and funded" the Arkansas Works program in April 2016, thus replacing the Private Option, which had so successfully lowered the rates of uninsured Arkansans.

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[40] *Ibid.*
[41] Margot Sanger-Katz, "Election Results Endanger Innovative Arkansas Medicaid Plan," *New York Times,* November 6, 2014. https://www.nytimes.com/2014/11/07/upshot/elections-put-future-of-innovative-arkansas-medicaid-plan-in-doubt.html?action=click&module=RelatedCoverage&pgtype=Article&region=Footer
[42] Margot Sanger-Katz, "Election Results Endanger Innovative Arkansas Medicaid Plan," *New York Times,* November 6, 2014. https://www.nytimes.com/2014/11/07/upshot/elections-put-future-of-innovative-arkansas-medicaid-plan-in-doubt.html?action=click&module=RelatedCoverage&pgtype=Article&region=Footer
[43] *Ibid.*
[44] Louise Norris, "Arkansas and the ACA's Medicaid Expansion," *Health Insurance.org,* November 25, 2018. https://www.healthinsurance.org/arkansas-medicaid/

Under Arkansas Works, DHS began referring all enrollees to the Arkansas Department of Workforce Services (DWS)" so as to encourage Medicaid beneficiaries "to voluntarily seek assistance with job training and job placement."[45] Although the work referral was strictly voluntary, its implementation implicitly established that Medicaid had a role to play in encouraging workforce participation among low-income individuals. The state found the results of the voluntary work referrals to be underwhelming: "From January to October 2017, only 4.7 percent of beneficiaries acted upon the referral and used the services offered by DWS. Of that number, 23 percent became employed through this process."[46] From these findings, the state concluded that voluntary referrals were not "an effective incentive" to encourage Arkansas Works beneficiaries to engage in work-related activities.[47] That is, by the lights of Arkansas DHS, Governor Hutchinson, and Administrator Verma, not enough individuals were "climbing the economic ladder" and getting off Medicaid.[48] In light of the poor referral uptake, the state desired a way to increase the consequences of not working.

In July 2017, Arkansas DHS publicly acted on this desire when they submitted their two-part Section 1115 waiver request to CMS. The first request in the waiver was to require "certain able-bodied adults without dependents (ABAWD) to participate in work and community engagement (WCE) requirements" or else lose access to Medicaid benefits under Arkansas Works.[49] This requirement became known as the "the reporting requirement" and included a lock-out period of up to nine months if a beneficiary failed to report at least 80 WCE hours per month for any given three months in a calendar year.[50]

The state's second request was "to reduce the number of people eligible for Medicaid by allowing only those with incomes below the federal poverty level, or about $12,140 [a year] for an individual, to

[45] Arkansas Department of Human Services, *Arkansas Works Quarterly Report April 1, 2018 – June 30, 2018*.
[46] Seema Verma, MPH to Cindy Gillespie, "Approving Arkansas's request," March 5, 2018, 4.
[47] *Ibid.*
[48] Seema Verma, MPH to Cindy Gillespie, "Approving Arkansas's request," March 5, 2018
[49] *Ibid.*
[50] *Ibid.*

qualify" (Galewitz, 2018). CMS ultimately denied the second request, but it is important to note that granting this request "would have cut the number of people eligible for Medicaid in the state by 60,000 people" (Galewitz, 2018). In light of Governor Hutchinson's outward appeal to Republican legislators who staunchly opposed the ACA Medicaid expansion, this request illustrates the state's underlying goal to reduce Medicaid coverage to low-income Arkansans.

As Arkansas awaited the decision from CMS, enrollment in the Arkansas Works program fell sharply in 2017. In fact, from January 1 2017 to July 1 2018, the rate at which Arkansas dropped Medicaid beneficiaries was faster "than any other state that chose to expand Medicaid."[51] What's more, this "shedding" of enrollees was far from accidental. Governor Hutchinson proudly announced in a January 2018 press conference that enrollment in Medicaid had declined "by almost 10 percent over the [previous] year – from 1,048,000 on Jan. 1, 2017, to 931,000 on Jan. 1, 2018."[52] The governor emphasized how the reduction in beneficiaries was expected to "significantly reduce the projected cost of the program" for 2018.[53] Regarding Arkansas Works beneficiaries in particular, enrollment alarmingly fell by nearly 60,000, from 344,289 in the beginning of 2017 to 285,564 by January 1, 2018.[54]

Governor Hutchinson declared this mass reduction in Arkansas Works enrollment to be a great success, not because he believed that Medicaid was providing higher quality healthcare, but because he considered the drop in enrollment as "a good indication that those on Medicaid are moving up the economic ladder" and "moving off of Medicaid."[55] The documented reasons for account closure, however, do not support this conclusion. Among those who lost coverage, the most common reason was that DHS was "unable to locate client or moved out-of-state" (39%), followed by "fail[ing] to return

[51] Benjamin Hardy, "Scrubbed from the System," *Arkansas Times,* August 9, 2018. https://www.arktimes.com/arkansas/scrubbed-from-the-system/Content?oid=21285998
[52] Benjamin Hardy, "Governor points to declining Medicaid rolls in seeking renewal of Arkansas Works from legislature," *Arkansas Times,* January 3, 2018. https://www.arktimes.com/arkansas/governor-points-to-declining-medicaid-rolls-in-seeking-renewal-of-arkansas-works-from-legislature/Content?oid=13350200
[53] *Ibid.*
[54] *Ibid.*
[55] *Ibid.*

requested information" (21%) and "Other" (20%).[56] Only 5% of individuals who lost coverage "requested closure" and only 11% lost eligibility because of an increase in household income.[57] This data renders Governor Hutchinson's analysis unconvincing, giving rise to the concern that Hutchinson may have been less interested in the consequences of coverage loss for Medicaid beneficiaries as he was in the consequences for the state budget. This concern is bolstered by the fact that at the same press conference, Hutchinson referred to the thousands of newly uninsured poor Americans as "good news, without question, for Arkansas taxpayers."[58] He then went on to present a series of conflicting statements regarding the state of Arkansas' workforce. On the one hand, he stated that more Arkansans were working than at any time in the state's history. On the other hand, he announced his plan to use a Section 1115 waiver to require those enrolled in Arkansas Works to hold a job.[59] This announcement signaled Governor Hutchinson's intentions to align his vision for Arkansas Works with the vision expressed by Brian Neale to use Medicaid as a means of "targeting … productive work and community engagement."[60] Throughout the press conference, the governor only discussed promoting coverage in response to concerns that the state's savings was coming at a sacrifice to "quality of service" for beneficiaries. While the Governor insisted this was not the case, he made a point to say that

> "with bending the cost curve, with rolling off 115,000 people from the Medicaid rolls, I think this is news that … will be well-received by the legislature. … They're rightfully concerned about … the Medicaid growth and this should give them a higher level of confidence that this trend will continue."[61]

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[56] *Ibid.*
[57] *Ibid.*
[58] *Ibid.*
[59] Benjamin Hardy, "Governor points to declining Medicaid rolls in seeking renewal of Arkansas Works from legislature," *Arkansas Times*, January 3, 2018. https://www.arktimes.com/arkansas/governor-points-to-declining-medicaid-rolls-in-seeking-renewal-of-arkansas-works-from-legislature/Content?oid=13350200
[60] Brian Neale See "A New Focus for CMS: Workforce Participation" in Chapter 1
[61] *Ibid.*

C. Details of the Arkansas Works WCE Requirement

Only three months later, on March 5, 2018, CMS issued its split decision on Arkansas' waiver, in which the WCE requirement was approved while the state's request to "roll back its Medicaid expansion" was denied (Galewitz, 2018). In outlining CMS's specific WCE approval, Verma states that the agency

> "Believe[s] that state Medicaid programs should be able to design and test incentives for beneficiary compliance. Under Arkansas's demonstration, the state will encourage compliance by making it a condition of continued coverage. Beneficiaries that successfully report compliance on a monthly basis will have no disruption in coverage. It is only when a beneficiary fails to report compliance for 3 months that the state will dis-enroll the beneficiary for the remainder of the calendar year. Beneficiaries that are disenrolled from their plan will be able to re-enroll through Arkansas Works upon the earlier of turning age 50, qualifying for another category of Medicaid eligibility, or the beginning of a new calendar year."[62]

Compliance is achieved by "either meeting SNAP work requirements or by completing at least 80 hours per month of some combination of the following activities as deemed appropriate by the state."[63]):

- "Employment or self-employment, or having an income that is consistent with being employed or self-employed at least 80 hours per month
- Enrollment in an educational program, including high school, higher education, or GED classes
- Participation in on-the-job-training
- Participation in vocational training
- Community Service
- Participation in independent job search (up to 40 hours per month)
- Participation in job searching training (up to 40 hours per month)
- Participation in a class on health insurance, using the health system, or healthy living (up to 20 hours per year)
- Participation in activities or programs available through the Arkansas Department of Workforce Services

[62] Seema Verma to Cindy Gillespie, March 5, 2018.
[63] Arkansas Department of Human Services, *Arkansas Works Program: December 2018*

- Participation in and compliance with SNAP/Transitional Employment Assistance (TEA) employment initiative programs."[64]

The WCE requirement also built in a pre-screened list of populations who are not "required to complete community engagement related activities to maintain eligibility."[65] A beneficiary is automatically exempt from this requirement if she

- Is identified as medically frail
- Is pregnant or 60 days postpartum
- Is a full time student
- Is exempt from Supplemental Nutrition Assistance Program (SNAP) community engagement requirements
- Receives TEA Cash Assistance
- Is "incapacitated in the short-term, is medically certified as physically or mentally unfit for employment, or has an acute medical condition validated by a medical professional that would prevent .. her from complying with the requirements."[66]
- Is caring for an incapacitated person
- Lives in a home with her "minor dependent child age 17 or younger."[67]
- Is receiving unemployment benefits
- Is currently participating in a treatment program for alcoholism or drug addiction

While the state has continually emphasized this long list of exemptions, it remains the case that under the WCE reporting requirement, the state holds the ultimate power to determine what is and what is not a legitimate reason not to partake in WCE activities. In order to report an exemption, the beneficiary may report "via electronic submission" with special accomodations available to those who "have difficulty reporting work activities."[68]

[64] Centers for Medicare and Medicaid Services, *Expenditure Authority No. 11-W-00287/6: Arkansas Works Section 1115 Demonstration*, by Seema Verma, 20.
[65] *Ibid.,* 19.
[66] *Ibid.*
[67] *Ibid.*
[68] "Attachment A: Eligibility and Enrollment Monitoring Plan," Centers for Medicare and Medicaid Services, *Expenditure Authority No. 11-W-00287/6: Arkansas Works Section 1115 Demonstration*, 5.

A beneficiary may also avoid losing coverage if failure to comply with the WCE requirement is deemed to be due to (1) disability or severe illness (on behalf of the beneficiary or an immediate family member living in the home), (2) "the birth, or death, of a family member living with the beneficiary," (3) "severe inclement weather (including a natural disaster) that renders him or her unable to meet the requirement, or (4) a "family emergency or other life-changing event (e.g. divorce or domestic violence."[69] While not limited to these "verified circumstances," these conditions qualify beneficiaries for a "good cause exemption" from the WCE requirement.[70] Anecdotally, some enrollees report that Arkansas DHS has approved exemption requests for reasons that fall outside of the "verified circumstances."[71]

It is also of note that when CMS approved of the WCE requirement, it approved of a staggered implementation process, in which the requirement would be rolled out in two stages. In the first stage (June 1 - January 1, 2018) the WCE requirement applied only to those within the expansion population who were between the ages of 30-49, subjecting approximately 69,000 beneficiaries to the requirement. Starting January 1, 2019, the WCE requirement expanded to include beneficiaries between the ages of 19-29, subjecting approximately 45,000 more people to the requirement.[72]

D. Public Justification

CMS considered the "proposed changes to Arkansas Works," including the WCE requirement, along three axes:

1. "Whether the demonstration as amended was likely to assist in improving health outcomes,"
2. Whether it would address behavioral and social factors that influence health outcomes, and,

[69] *Ibid.*
[70] *Ibid.*
[71] Gresham et al. v. Azar et al., Civil Action No. 1:18-cv-01900, 39 (2018)
[72] Benjamin Hardy, "Medicaid work requirement grows to include younger beneficiaries," *Arkansas Times*, February 15, 2019. https://www.arktimes.com/ArkansasBlog/archives/2019/02/15/medicaid-work-requirement-grows-to-include-younger-beneficiaries

3. Whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes."[73]

Ultimately, Seema Verma approved of the WCE requirement on behalf of CMS because, she argued, the policy is "specifically … designed to encourage beneficiaries to obtain and maintain employment or undertake other community engagement activities that research has shown to be correlated with improved health and wellness."[74] With this in mind, she maintained that the WCE requirement would "promote health and wellness through increased upward mobility, greater independence, and improved quality of life" for Arkansas's beneficiaries."[75]

Both Verma and Arkansas DHS Director Cindy Gillespie emphasized a sentiment of upward mobility, with Gillespie summarizing her proposal by reiterating that

> "Arkansas appreciates the opportunity to help our fellow Arkansans begin to move up the economic ladder through the Arkansas Works program with work and community engagement requirements … We have developed a strong team of partners ready to help these beneficiaries take the steps toward self-sufficiency."[76]

CMS also made it explicitly clear that the work requirement was in direct response to the low rates of participation in the voluntary work-referral program from the original Arkansas Works demonstration. In her approval of the WCE requirement, she cites that "through October 2017, only 4.7 percent of beneficiaries followed through with the referral and accessed DEW services," and only "23 percent [of those who accessed DWS services] have become employed."[77] According to Verma,

> "This result suggests that referrals alone, without any further incentive, may not be sufficient to encourage the Arkansas Works population to participate in community engagement activities.

[73] Seema Verma, MPH to Cindy Gillespie, "Approving Arkansas's request," March 5, 2018, 3.
[74] *Ibid.,* 3.
[75] *Ibid.,* 4.
[76] "Attachment A: Eligibility and Enrollment Monitoring Plan," Centers for Medicare and Medicaid Services, *Expenditure Authority No. 11-W-00287/6: Arkansas Works Section 1115 Demonstration*, 15.
[77] Seema Verma, MPH to Cindy Gillespie, "Approving Arkansas's request," March 5, 2018, 4.

> CMS will therefore allow Arkansas to test whether the stronger incentive model is more effective in encouraging participation."[78]

This sentiment confirms that CMS not only identified work-related activities as being in the best interest of Arkansas Works beneficiaries, but the agency and the state also deemed beneficiaries as being unable to govern themselves in such a way as to realize these interests without punitive measures.

In justifying the WCE requirement, CMS and the State of Arkansas also addressed several concerns raised during the state and federal public comment periods. One of the central concerns was that "the community engagement requirements would be burdensome for individuals and families or create barriers to coverage for non-exempt people who might have trouble accessing care."[79] Ms. Gillespie's response to this concern did not address the issue of barriers to coverage for non-exempt people. Rather, Ms. Gillespie reiterated on behalf of Arkansas DHS that

> "we believe that the community engagement requirements create appropriate incentives for beneficiaries to gain employment. Given that employment is positively correlated with health outcomes, it furthers the purposes of the Medicaid statute to test and evaluate these requirements as a means to improve beneficiaries' health and to promote beneficiary independence."[80]

DHS has also continually lauded its own "outreach and education" plan and its intent "to use an online reporting system to make reporting easy for enrollees."[81]

Some opponents of the online reporting system have, however, raised concerns over an uneven distribution of computer skills that may systematically and unfairly prevent some individuals from being able to report their hours. To this end, DHS has insisted that "use of the portal promotes work and

[78] *Ibid*.
[79] *Ibid, 5.*
[80] *Ibid.,* 5.
[81] "Attachment A: Eligibility and Enrollment Monitoring Plan," Centers for Medicare and Medicaid Services, *Expenditure Authority No. 11-W-00287/6: Arkansas Works Section 1115 Demonstration*, 5.

community engagement goals by reinforcing basic computer skills, internet navigation, and communication via email."[82]

The third central concern raised during the public comment periods concerned the fact that "the maximum [lockout] period is longer than what has been proposed in other state demonstration applications and does not offer any way to regain eligibility during the [lockout] period."[83] In response, CMS emphasizes that "the program provides the individual with three opportunities to rectify the situation or seek an exemption. Any system that requires individuals to fulfill certain requirements as a condition of receiving benefits necessarily places some degree of responsibility on these individuals. We believe that the overall health benefits to the effected population through community engagement outweigh the health-risks with respect to those who fail to respond and who fail to seek exemption from the programs limited requirements" (sic).[84] Verma's comment seems to assume that individuals will successfully seek exemption if they are in critical need of one, meaning that those who fail to seek exemption will likely experience health-risks that. Alternatively, she may have been assuming that the WCE requirement would promote such impressive net health benefits for its subject beneficiaries that even if a few individuals who critically need exemptions failed to receive them, the requirement and its lockout period would remain justifiable. As the actual consequences of the WCE requirement reveal, however, neither of these assumptions proved true.

E. Consequences of Arkansas' WCE Requirement

On June 1, 2018, Arkansas's DHS began implementing the reporting requirement and the downward trend of Medicaid enrollment that Governor Hutchinson anticipated soon continued. By the beginning of August, the first month in which beneficiaries could lose coverage for failing to comply with

[82] "Attachment A: Eligibility and Enrollment Monitoring Plan," Centers for Medicare and Medicaid Services, *Expenditure Authority No. 11-W-00287/6: Arkansas Works Section 1115 Demonstration*, 5.
[83] Seema Verma, MPH to Cindy Gillespie, "Approving Arkansas's request," March 5, 2018, 6.
[84] *Ibid.*, 6.

the WCE requirement, over 4,000 individuals, out of 60,012, lost coverage and were locked out for the remainder of the calendar year. This trend continued at comparative levels throughout the end of the year, though it is notable that December saw remarkably fewer cases closed than in the months prior. Over the span of five months, 18,164 individuals lost healthcare coverage due to failure to comply with the WCE requirement.[85]

As Table 1 indicates, an average of 1.61% of subject beneficiaries satisfied the WCE requirement by reporting 80+ WCE hours per month.[86] This figure includes all beneficiaries who were identified as being subject to the WCE requirement, including those who "are already meeting the requirement through work, school, or other life situations that made them exempt from reporting each month."[87] The percentage of beneficiaries who are meeting the WCE requirement reporting via reporting is startlingly low compared to 79.75% of beneficiaries who are deemed "already meeting the requirement" and thus exempt from reporting.[88] Of the remaining individuals who are not granted initial exemption, a substantive 18.64% fail to report 80+ of such hours.[89]

In the monthly reports released by Arkansas DHS, the agency reports how many subject enrollees satisfy the WCE requirement, citing figures as high as 92% compliance in December 2018 and 90% in January 2019.[90] These two figures, which indicate the highest degrees of "compliance" of any other months under the WCE requirement, are somewhat misleading. In December, 92.13% of subject enrollees were "exempt from reporting activities because DHS already has the information showing they are in compliance."[91] In January, the figure was 90.25% of subject enrollees.[92] These data indicate that nearly 100% of compliance is due not to successful reporting, but to exemptions from the policy itself. Moreover, the high degrees of similarity between rate of compliance and rate of pre-emptive exemption

[85] Arkansas Department of Human Services, *Arkansas Works Program: February 2019*
[86] *Ibid.*
[87] *Ibid.*
[88] *Ibid.*
[89] *Ibid.*
[90] *Ibid.*
[91] Arkansas Department of Human Services, *Arkansas Works Program: December 2018*
[92] Arkansas Department of Human Services, *Arkansas Works Program: February 2019*

are not unique to the months of December and January. A monthly average of 77.8% of subject enrollees are exempt from reporting activities solely because DHS has the documentation necessary to conclude that the enrollee is sufficiently engaged in "work, training, or other activity" on a full-time basis.[93] DHS handles such exemptions on a case by case basis, leaving many beneficiaries still unsure as to what exactly this documentation must include.[94] DHS has confirmed that an individual can receive exemption by providing the agency with sufficient evidence that his or her income is equal to or greater than $736 per month.[95] At the same time, some beneficiaries, such as the plaintiff Mr. Cardon, have attempted to obtain this exemption by submitting income information via a "DHS form for odd jobs" but were never notified as to whether they were granted exemption.[96] The top three most commonly granted exemptions have been presumed employment (37.9% of enrollees a month), followed by pre-existing exemption from SNAP requirements (12.79%), and medical frailty (10.83%).[97]

[93] Arkansas Department of Human Services, *Arkansas Works Program: June 2018*
[94] Gresham et al. v. Azar et al., Civil Action No. 1:18-cv-01900, 35 (2018)
[95] Centers for Medicare and Medicaid Services, *Expenditure Authority No. 11-W-00287/6: Arkansas Works Section 1115 Demonstration*, by Seema Verma, 20.
[96] Gresham et al. v. Azar et al., Civil Action No. 1:18-cv-01900, 37 (2018)
[97] Arkansas Department of Human Services, *Arkansas Works Program: February 2019*

- EXTEROVICH-RUBIN

Table 1

	Jun. 2018	Jul. 2018	Aug. 2018	Sept. 2018	Oct. 2018	Nov. 2019	Dec. 2018	Jan. 2019	Feb. 2019	**Avg. % of Total**
Total enrollees subject to WCE requirement	25,815	43,794	60,012	73,266	69,041	64,743	60,680	105,158	116,229	100%
Met requirement **by pre-exemption** (% of subject enrollees)	17,906 (69.37%)	30,228 (69.02%)	42,437 (70.71%)	54,977 (75.04%)	55,388 (80.22)	54,889 (84.78%)	54,593 (89.97%)	93,327 (88.75%)	101,115 (86.99%)	79.75%
Met requirement **by reporting 80+ WCE hours** (% of subject enrollees)	445 (1.72%)	844 (1.93%)	1,218 (2.03%)	1,532 (2.09%)	1,525 (2.21%)	1,428 (2.21%)	1,311 (2.16%)	1,573 (1.50%)	1,741 (1.50%)	1.61%
Failed to meet requirement (% of subject enrollees)	7,464 (28.91%)	12,722 (29.05%)	16,357 (27.26%)	16,757 (22.87%)	12,128 (17.57%)	8,426 (13.01%)	4,776 (7.87%)	10,258 (9.75%)	13,373 (11.51%)	18.64%
										Total
Lost coverage due to 3 months of failed reporting	-	-	4,353	4,109	3,815	4,655	1,232	-	-	18,164

Data Source: Arkansas Department of Human Services, *Arkansas Works Program: February 2019*

F. Growing Opposition

Following CMS's public approval of Arkansas's WCE requirement, opposition poured from groups such as the American Psychological Association (APA), the Medicaid and CHIP Payment and Access Commission, and effected Arkansas Works enrollees, including those being represented in the class action court case against the requirement. In a public letter addressed to Seema Verma, Clinton

Anderson, APA Interim Executive Director, expressed concern that WCE requirements at large "will hurt unemployed people across the country in fundamental ways that counter the government's obligation to provide a safety net for our most vulnerable citizens."[98] The letter further emphasizes that "many of these recipients will be forced to make a 'choice' - either leave a Medicaid program that provides essential treatment and enables the possibility of seeking meaningful employment, or seek low-wage temporary employment that can compromise health and well-being."[99]

The Medicaid and CHIP Payment and Access Commission (MACPAC), a nonpartisan advisory agency within the legislative branch, issued an alarmed letter to Secretary Azar on November 8, 2018 regarding the degree of health care coverage loss under the WCE requirement. MACPAC Chair Penny Thompson authored the letter on behalf of the Commissioners, expressing that the Commission was "highly concerned" about the 8,462 Arkansans who had been disenrolled and locked out from healthcare coverage as of November.[100] Pointing to the lack of both awareness and internet access on behalf of enrollees, Thompson suggests that the very low WCE reporting rates serve as "a strong warning signal" that the structure of Arkansas's WCE requirement does not "[provide] individuals an opportunity to succeed, with high stakes for beneficiaries who fail."[101] Though the Commission clearly opposed the way Arkansas Works was implemented, its letter carefully avoids commenting on the permissibility of WCE requirements writ large, assuring Secretary Azar that "MACPAC is not commenting here on the merits of work and community engagement requirements."[102] The Commission instead focuses its concerns on "the number of beneficiaries losing coverage" under the specific requirement in addition to both Arkansas's "short implementation timeframe" and the "absence of sufficient measures and data to interpret early results and guide adjustments."[103] Ultimately, the Commission "urge[d] HHS to pause disenrollments

[98] Clinton Anderson, Ph.D to Seema Verma, MPH February 13, 2018.
[99] *Ibid.*
[100] Penny Thompson to Alex Azar, November 8, 2018.
[101] *Ibid.*
[102] *Ibid.*
[103] *Ibid.*

under the [Arkansas Works] waiver" and suggested that "federal and state governments" adjust the WCE requirement to "promote awareness, reporting, and compliance.[104]

Seema Verma responded to this letter on behalf of Secretary Azar on February 6, 2019, three months after MACPAC's initial note. In her short response, Verma dismisses MACPAC's concerns by citing Arkansas's "numerous online and print outreach and education efforts" as well as the state's addition of a "helpline that will permit beneficiaries to report this information directly to the state by telephone."[105] Verma reiterates that "CMS is committed to continuing to support states' … community engagement requirements" specifically because "CMS believes such opportunities put beneficiaries in control to live healthier and more independent lives" (Verma, 2019). Nowhere in her response does Verma address MACPAC's concern over coverage loss. She does not mention the 8,462 individuals cited by MACPAC, nor the 9,702 additional individuals who lost their coverage in the time it took her to respond.[106]

Aside from health policy experts, Arkansas beneficiaries have also expressed dismay, confusion, and anxiety surrounding the WCE requirement. Robert Smith, a 48 year old beneficiary with chronic back problems and a torn rotator cuff, told the Arkansas Times that he "didn't even know nothing about it until it was too late. And, I mean, how are you supposed to work if your back's messed up? Do I have to go and volunteer 80 hours somewhere? I don't understand what they're wanting."[107] Like a number of other beneficiaries, Smith has found the WCE requirement confusing, its implementation rushed, and its requirements seemingly unattainable. Smith's story is particularly telling, however, because by Smith's lights, he's achieved self-sufficiency and was choosing not to work as a means of taking care of himself – and yet the government is now requiring him to work in order to receive healthcare benefits. Smith laments, "You know, my kids are raised. I don't owe nobody, nobody owes me nothing, so I took the last

[104] Penny Thompson to Alex Azar, November 8, 2018.
[105] Seema Verma, MPH to Clinton Anderson, Ph.D. February 6, 2019.
[106] Arkansas Department of Human Services, *Arkansas Works Program: March 2019*
[107] Benjamin Hardy, "Locked out of Medicaid," *Arkansas Times*, November 19, 2018. https://www.arktimes.com/arkansas/when-arkansas-works-doesnt/Content?oid=25890378

year and a half off just for me … because I've been killing myself all my life."[108] With the WCE requirement in place, however, Smith now works part-time as a garbage hauler despite his severe back pain.[109] He laments that the work is "pretty tough," but that "you just gotta bear it and do what you gotta do."[110]

Smith's story closely resembles the stories of the nine plaintiffs in the class action Federal Court case against Arkansas' WCE requirement, *Gresham, et al., v. Azar, et al.* The case was first filed on behalf of three plaintiffs on August 14, 2018, even before the state began locking individuals out of coverage. It was then re-submitted on November 5, 2018 when six new plaintiffs were added to the complaint. In total, there are now nine plaintiffs who are being represented by counsel from Legal Aid of Arkansas, The National Health Law Program, and the Southern Poverty Law Center. While I will focus here on the plaintiffs' experiences under the WCE requirement, it may provide helpful context to note that the central charge of the case is that

> "The State Medicaid Director Letter and subsequent approval of Arkansas' application are unauthorized attempts to rewrite the Medicaid Act, … the use of the Social Security Act's waiver authority to "transform" Medicaid is an abuse of authority," and "the Defendants' actions here … cannot survive."[111]

I will address both of these regulatory concerns in Chapter 4. Here, however, I turn my focus back to the plaintiffs. Of the nine total plaintiffs, four were employed, four were unable to work due to their severe health issues, and one had become unemployed as a direct result of the WCE requirement revoking his access to critical medications. The latter was the case of Adrian McGonigal, age 40, who currently takes eight prescription medications and has regular visits to his primary care doctor and pulmonologist to treat his Chronic Obstructive Pulmonary Disease (COPD), degenerative disc disease,

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[108] Benjamin Hardy, "Locked out of Medicaid," *Arkansas Times*, November 19, 2018. https://www.arktimes.com/arkansas/when-arkansas-works-doesnt/Content?oid=25890378
[109] *Ibid.*
[110] *Ibid.*
[111] Gresham et al. v. Azar et al., Civil Action No. 1:18-cv-01900, 5 (2018).

depression, and anxiety disorder.[112] In August 2018, he left his job in the fast food industry to begin working at Southwest Poultry, first in the processing department and later the shipping department after "exposure to chemicals [in the processing department] aggravated his … COPD."[113] In his new position, McGonigal was working 30 to 40 hours a week and earning approximately $1200 a month before taxes.[114] Despite experiencing "continued … problems associated with his COPD and [having] to take frequent breaks," McGonigal reported that "he could do his job and not miss much work as long as he had his medications.[115] These medications were previously covered for McGonigal under Arkansas Works. When McGonigal attempted to fill his prescriptions on October 5, 2018, however, his pharmacist informed him that he was no longer covered by Medicaid, which DHS later confirmed was due to his failure to report his work hours. Without insurance, McGonigal could not afford the $800 bill to fill his COPD medications, "so he went without his medicine."[116] According to the complaint, foregoing his medication caused his COPD to flare up, and

> "since he no longer had health coverage, he had to go to the emergency room for treatment and missed several days of work. He had no choice but to recover at home because the hospital would not permit him to remain there without insurance. He expects to receive a bill for his hospital stay.
>
> Pursuant to Southwest Poultry's absence policy, Mr. McGonigal accrued a demerit for every day of work he missed …. On October 22, 2018 his employer fired him because of his absences."[117]

McGonigal's case presents a clear demonstration of how the WCE requirement has hindered not only enrollees' physical health, but also their prospects of attaining and maintaining employment.

[112] Gresham et al. v. Azar et al., Civil Action No. 1:18-cv-01900, 34 (2018)
[113] *Ibid.,* 33
[114] *Ibid.*
[115] *Ibid.*
[116] *Ibid.,* 34
[117] *Ibid.*

The WCE requirement has also wrought negative consequences on plaintiffs' mental health. Three of the plaintiffs reported that "the threat of losing health coverage because of the work requirement" has prompted anxiety attacks and/or panic attacks.[118] Because of this threat, the plaintiff Ms. Ardon reported that she "began to have multiple panic attacks a day" for two consecutive months.[119] Mr. Gresham, the principal plaintiff, disclosed that he "discusses the work requirements and potential loss of coverage at each appointment with his therapist." [120] Further, he has ongoing fears that if he loses his medical coverage "his conditions will get worse and he may suffer irreversible harm or die."[121] All of the plaintiffs expressed poignant "fear," "uncertain[ty]," and/or "worr[y]" regarding the prospects of losing healthcare coverage. These sentiments mirror the fear and uncertainty among beneficiaries who have publicly commented on their experiences in interviews with local and national news outlets, as with the case of Kadie Campbell. She expressed frustration at the rigidity of the reporting requirements, which had failed to recognize her graduate work as a student exemption. Unlike many other beneficiaries, Campbell had "the luxury of being able to sit around on the phone for as long as it takes to get ahold of somebody-and being eloquent enough to explain [her] situation."[122]

In the face of a growing disenrolled population and criticism that the policy undermined Medicaid's goals, Governor Hutchinson has continued to defend the requirement. He has maintained that "compassion and common sense says this is a good program for those that are trying to move up the economic ladder and to better themselves. It's also about providing assistance to those who need it. And it is also about the value of work and responsibility."[123] It remains unclear, however, if the reporting

[118] Gresham et al. v. Azar et al., Civil Action No. 1:18-cv-01900, 33, 36, 39 (2018)
[119] *Ibid.,* 39
[120] *Ibid.,* 33
[121] *Ibid.*
[122] Benjamin Hardy, "Locked out of Medicaid," *Arkansas Times*, November 19, 2018. https://www.arktimes.com/arkansas/when-arkansas-works-doesnt/Content?oid=25890378
[123] Benjamin Hardy, "Work requirement bars over 4,000 from receiving Medicaid coverage," *Arkansas Times,* September 13, 2018. https://www.arktimes.com/arkansas/work-requirement-bars-over-4000-from-receiving-medicaid-coverage/Content?oid=23041407

requirement is actually helping beneficiaries "move up the economic ladder." In November, DWS spokesperson Steven Guntharp disclosed to the Arkansas Times that "workforce centers haven't seen a major rise in casework recently ... and DWS hasn't hired additional staff."[124] Further, out of the nearly 70,000 people subject to the requirement as of November 14, only 2,887 (roughly 4.12%) had obtained "full-time employment since the requirement started."[125] These comments leave open the question of whether the requirement is actually strengthening the workforce.

January 1, 2019 marked the first opportunity for disenrolled individuals to regain coverage since the WCE requirement was implemented. Since January 1, however, re-enrollment numbers have remained staggeringly low. As of February 15, 2019, only 1,452 of the 18,164 total disenrolled individuals "applied for and regained coverage so far in 2019" (Hardy, 2019). It is not clear what is preventing disenrolled individuals from re-applying, but Governor Hutchinson has suggested that the low reuptake might "mean that these individuals got insurance elsewhere and so they have no need to re-enroll," or it might indicate "that they just don't care."[126] Critics, however, have refuted this suggestion, arguing that the requirement's overly complex rules and processes have prevented people from reapplying for coverage.[127] They argue that low rates of re-enrollment do not indicate a "lack of need" for publicly provisioned insurance.[128] Many beneficiaries who lost coverage in 2018 expressed that they only became aware of the policy and how to comply with it after they had their coverage revoked. In light of this overwhelming lack of understanding or even awareness, opponents of the WCE requirement have pointed out that many individuals who lost coverage under this policy likely did not know they would regain eligibility for coverage as of January 1.[129] Moreover, according to Jennifer Wagner, Senior Policy Analyst

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[124] Benjamin Hardy, "Locked out of Medicaid," *Arkansas Times*, November 19, 2018. https://www.arktimes.com/arkansas/when-arkansas-works-doesnt/Content?oid=25890378
[125] *Ibid.*
[126] Benjamin Hardy, "Over 18,000 Lost Coverage in 2018 Due to Medicaid Work Rule, but Only Fraction Have Reapplied," *Arkansas Times,* January 15, 2019. https://www.arktimes.com/ArkansasBlog/archives/2019/01/15/over-18000-lost-coverage-in-2018-due-to-medicaid-work-rule-but-only-fraction-have-reapplied
[127] *Ibid.*
[128] *Ibid.*
[129] *Ibid.*

with the Center for Budget and Policy Priorities, "others did not know they could reapply beginning in December for coverage effective January 1 or have circumstances in their lives that have prevented them from initiating a new application. Or, knowing that they will likely be terminated again in 3 months, some could be 'saving' their months of eligibility for when they need it most."[130] Until a survey is conducted of beneficiaries, however, we will not be able to determine the true reasons underlying the low rates of re-enrollment.

III. HISTORY OF WELFARE WORK REQUIREMENTS

Only under the Trump administration have states been able to pursue Medicaid work requirements successfully. This is not, however, for lack of trying. Many were inspired by the WCE requirement of the flagship welfare policy, Temporary Assistance to Needy Families (TANF), a federal cash-transfer program implemented under the Clinton administration. In this chapter, I consider the extent to which TANF ushered in an aggressive "pro-self sufficiency" campaign that expected welfare recipients to "earn" their benefits. I then discuss the ways in which states tried, and failed, during the Obama era to similarly punish individuals through leveraging Medicaid benefits. By denying states' desire to attach WCE requirements to Medicaid, the CMS leadership under Obama signaled that Medicaid's goal of of "promoting health" ought to be subverted by the goal of encouraging workforce participation.

A. TANF

While states have only recently begun attaching a work requirement to Medicaid, this trend follows a national proliferation of state-level work requirements for means-tested welfare programs over the past twenty years, namely for Temporary Assistance for Needy Families (TANF). In 1996, President Clinton signed into law the Personal Responsibility and Work Opportunity Reconciliation Act of 1996

[130] Benjamin Hardy, "Over 18,000 Lost Coverage in 2018 Due to Medicaid Work Rule, but Only Fraction Have Reapplied," *Arkansas Times,* January 15, 2019. https://www.arktimes.com/ArkansasBlog/archives/2019/01/15/over-18000-lost-coverage-in-2018-due-to-medicaid-work-rule-but-only-fraction-have-reapplied

(PRWORA), which had the stated goals of reducing welfare dependency, reducing out-of-wedlock pregnancy, and encouraging two-parent households.[131] With PRWORA, the Clinton administration replaced the federally-centralized welfare program Aid to Families with Dependent Children (AFDC) with TANF, a block-grant style program that allowed state governments to design and experiment with their cash-benefit welfare programs. TANF also imposed a strict sixty-month lifetime limit on cash-benefits and required that recipients in any state engage in part-time work and demonstrate that they are moving towards full-time employment in order to keep receiving benefits.[132] States began using the programmatic freedom under TANF to customize their work requirements further and to attach other behavioral incentive structures to their cash-benefits programs. PRWORA and TANF effectively marked a renewed commitment among policymakers to aggressively encourage workforce participation by leveraging welfare benefits, setting a precedent for other means-tested welfare programs to follow suit.[133][134]

B. Evolution of Medicaid's Work Requirements and Objectives

While February 2018 marked a novel trend of CMS approving state governments to implement Medicaid work requirements, states have been attempting to receive this approval from the federal government for decades – and were routinely denied. In August of 2016, New Hampshire submitted a proposal to CMS to amend its Medicaid policy so as to include, among other things, a work requirement. CMS rejected this proposal due to two central concerns: adverse consequences and a subversion of Medicaid's original goals.[135] Former Deputy Director of CMS, Vicki Wachino expressed concern that

[131] Steven Anderson and Brian Gryzlak, "Social work advocacy in the post-TANF environment: Lessons from early TANF research studies," *Social Work*, 47, no. 3 (July 2002): 302
[132] Amy Wax, "Something for Nothing: Liberal Justice and Welfare Work Requirements," *Emory Law Journal*, 52, no. 1 (2003): 1
[133] Lawrence Mead, "Telling the Poor What to Do" *Public Interest,* 132 (Summer, 1998): 97
[134] Maria Cancian, "Rhetoric and Reality of Work-Based Welfare Reform," *Social Work,* 46, no. 4 (October 2001): 309
[135] Vicki Wachino to Jeffrey Meyers, November 1, 2016, 1. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-cms-response-110116.pdf

each of the proposed changes "could undermine access … of care provided to Medicaid beneficiaries."[136] In addition to these outcome-oriented concerns, Wachino explicitly stated that such changes "do not support the objectives of the Medicaid program."[137]

In July of the same year, Indiana submitted a proposal to amend their own state Medicaid program, entitled "HIP 2.0." While not requesting a work requirement, the state did request to add "a lockout from coverage for Medicaid beneficiaries, regardless of income level, who do not complete the annual eligibility redetermination process."[138] CMS denied this request on the following grounds:

> Authorizing a lockout for individuals at any income level who do not complete their annual eligibility redetermination is *not consistent with the objectives of the Medicaid program*, which include ensuring access to affordable coverage. Many low-income individuals face challenges in completing the redetermination process. These challenges include language access issues, as well as frequent moves and other difficulties obtaining their mail. Low-income individuals are also more likely to experience disabling conditions, including mental illness, or face temporary or chronic homelessness. Such conditions make completing the tasks associated with the redetermination process in a timely manner challenging. For example, the eligibility redetermination deadline may coincide with an acute health event or loss of housing.
>
> Maintaining access to health coverage for such individuals is important, as it promotes access to treatment and medication that can prevent physical or behavioral health conditions from worsening. Under the proposed lockout, however, low-income individuals who fail to complete redetermination paperwork due to any of these challenges would then be barred from obtaining treatment under Medicaid for their condition for six months. Your letter notes that five percent of the HIP 2.0 population do not complete the renewal process. That means that under the state's proposed lockout approximately 18,850 people would be excluded from coverage each year.[139] (emphasis added)

[136] Vicki Wachino to Jeffrey Meyers, November 1, 2016, 1. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-cms-response-110116.pdf
[137] *Ibid.,* 1.
[138] Vicki Wachino, "State Demonstration Group," to Tyler Ann McGuffee, July 29, 2016. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf
[139] *Ibid.,* 2.

Wachino also states directly that "exclusions from coverage, such as lockouts, are not permitted under Medicaid law."[140] Before Indiana's July 2016 amendment proposal, CMS made a special exception to this law for "Indiana's unique lockout for people with incomes above 100 percent of the FPL," on the condition that CMS would "undertake a rigorous evaluation of the effects of that policy."[141] When CMS denied Indiana's request to expand this lockout to all recipients who failed to complete the annual eligibility redetermination process, Wachino made it clear that "we did not authorize in Indiana, nor have we since authorized in any section 1115 demonstration, lockouts for individuals with incomes below 100 percent of the FPL. Likewise, we did not authorize in Indiana, nor have we since authorized in any section 1115 demonstration, lockouts for individuals who do not complete the redetermination process."[142] CMS disapproved of the state's proposals, which overlooked the complications facing low income individuals as well as the logistical barriers involved with the adequate completion, submission, and acceptance of additional paperwork.

In early March 2017, however, following the transition of leadership under President Trump and the installation of Seema Verma as CMS Administrator, the objectives of CMS took on a starkly different interpretation. In a letter sent out to every U.S. Governor, Administrator Verma and Secretary Price state that "the expansion of Medicaid through the ACA to non-disabled, working adults without dependent children was a clear departure from the core, historical mission of the program."[143] In this same letter, Verma and Price explicitly establish that CMS will be adopting a reinterpretation of Medicaid's role in recipients' employment stating the following:

"Today, we reaffirm the agency's commitment to support and complement the various federal, state, and local programs that have demonstrated success in assisting eligible low-income adult beneficiaries to improve their economic standing and materially advance in an effort to rise out of poverty**.** *The best way to improve the long-term health of low-income Americans is to empower them with*

[140] Vicki Wachino, "State Demonstration Group," to Tyler Ann McGuffee, July 29, 2016, 1. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf
[141] *Ibid,* 1.
[142] *Ibid.,* 1.
[143] Thomas E. Price, M.D. and Seema Verma, MPH to Governors, 2017.

skills and employment. It is our intent to use Section 1115 demonstration authority to review and approve meritorious innovations that build on the human dignity that comes with training, employment, and independence" (emphasis added).[144]

While CMS had specifically denied Medicaid work requirements in 2016 to New Hampshire and Indiana, both states received approval two years later. Effective as of January 1, 2019, "able-bodied individuals between the ages of 19 to 64" in the state of New Hampshire are required to report working no fewer than 100 hours a month in order remain eligible for Medicaid.[145] Also effective January 1, 2019, able-bodied adult enrollees under 60 years old in Indiana must now report working 20 hours a week on average and "beneficiaries who fail to promptly complete the eligibility redetermination process will be locked out from the program for three months."[146]

Stewart et al., v. Azar et al.

The first first legal challenge to CMS's Medicaid work requirements came less than two weeks after CMS approved a Medicaid WCE requirement in Kentucky. The class action lawsuit was filed on January 24, 2018 in the District of Columbia federal court to "challenge [the] implementation" of Kentucky HEALTH.[147] The plaintiffs of the case, representing themselves as well as all individuals enrolled in the Kentucky Medicaid program on or before January 12, 2018, asked the court to overturn the policy as unlawful.[148] They alleged that the policy would leave them in danger of losing healthcare coverage and that "the defendant (HHS Secretary Alexander Azar) acted beyond the scope of his authority under Section 1115 waiver authority."[149]

[144] Thomas E. Price, M.D. and Seema Verma, MPH to Governors, 2017.
[145] Olivia Obasi, "The New Work Requirement for Medicaid," *American Bar Association Health eSource*, September 27, 2018. https://www.americanbar.org/groups/health_law/publications/aba_health_esource/2017-2018/june-2018/medicaid/
[146] *Ibid.*
[147] *Ibid.*
[148] *Ibid.*
[149] *Ibid.*

On June 29, 2019, Judge James Boasberg of the United States District Court for the District of Columbia ultimately overturned Kentucky's policy and "remanded the matter to HHS for further review."[150] Judge Boasberg concluded that by approving Kentucky's proposed Medicaid work and community engagement requirement, Secretary Azar failed to account for what Boasberg deemed a most critical concern to HHS: "whether Kentucky HEALTH would, in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid[151]" His ruling, however, was notably narrow and explicitly concerns Kentucky's policy alone. Judge Boasberg did not rule on the lawfulness of Section 1115 Medicaid work requirements writ large and he did not challenge the claims made by HHS Secretary Azar, CMS Administrator Verma, and CMS Secretary Price that work enhances one's health and that improving health through work is an objective of Medicaid.[152] Judge Boasberg's ruling thus suggests the following: in order for a future work requirement to be legal, the state's records would likely have to demonstrate inadequate consideration of the impact on the state's beneficiaries. Moreover, such an oversight would have to be extensive enough to constitute a failure to promote Medicaid's most fundamental objectives.[153]

In November of 2018, CMS re-approved Kentucky's work requirement waiver with minor revisions and the program will be "phased in regionally over several months," beginning April 1, 2019.[154] In response, Ronnie Stewart (the lead plaintiff in the first class action suit against the policy) filed in January 2019 against the revised policy, joining fifteen other Kentucky residents on Medicaid.[155]

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[150] Sara Rosenbaum, "Medicaid Work Requirements: Inside the Decision Overturning Kentucky HEALTH's Approval," *Health Affairs Blog,* July 2, 2018. https://www.healthaffairs.org/do/10.1377/hblog20180702.144007/full/
[151] *Stewart v. Azar,* 313 F. Supp. 3d 237 (D.D.C. 2018): 3.
[152] Sara Rosenbaum, "Medicaid Work Requirements: Inside the Decision Overturning Kentucky HEALTH's Approval," *Health Affairs Blog,* July 2, 2018.
[153] *Ibid.*
[154] Adam Beam, "Trump Administration Approves Kentucky's Medicaid Work Requirement Waiver," *PBS,* November 21, 2018. https://www.pbs.org/newshour/health/trump-administration-approves-kentuckys-medicaid-work-requirement-waiver
[155] John Cheves, "Medicaid Recipients File Suit Again to Block Bevin's Work Requirements and Premiums," *Lexington Herald Leader,* January 15, 2019. https://www.kentucky.com/news/politics-government/article224562970.html

B. Lack of Transparency & Vague Objectives

Even before CMS began approving Medicaid work requirements, there has been longstanding controversy over the transparency of the Section 1115 review and approval process and the specificity of what exactly Medicaid's objectives are in the first place. In September 2010, CMS formally attempted to address this by proposing a rule to "promote greater transparency in the review and approval of [Section 1115] demonstrations," by increasing "information" about demonstration applications and ensuring that "approved demonstration projects are publicly available."[156] In 2013, however, the Government Accountability Office (GAO) maintained "cost and transparency concerns" in light of CMS approving some state Section 1115 demonstrations, such as in Texas and Arizona, that violated "budget neutrality policy."[157] GAO and public officials alike have also criticized the overly vague nature of Medicaid's objectives themselves. In April 2015, GAO issued a third report which plainly stated:

> "Although section 1115 of the Social Security Act provides HHS with broad authority to approve expenditure authorities that, in the Secretary's judgment, are likely to promote Medicaid objectives, HHS has not issued specific criteria for making these determinations. Further, HHS's approval documents are not always clear as to what, precisely, approved expenditures are for and how they will promote Medicaid objective … Without clear criteria for assessing how proposed expenditure authorities states are seeking will promote Medicaid objectives, and without clear documentation of the application of those criteria, the bases for HHS's decisions involving tens of billions of Medicaid dollars are not transparent to Congress, states, or the public."[158]

In June of the same year, GAO reiterated similar concerns before House of Representatives' Subcommittee on Health, Committee on Energy and Commerce.[159] These sentiments were again echoed

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[156] Centers for Medicare and Medicaid, *Medicaid Program; Review and Approval Process for Section 1115 Demonstrations,* 75 FR 56946 (September 17, 2010). https://www.govinfo.gov/content/pkg/FR-2010-09-17/pdf/2010-23357.pdf

[157] U.S. Government Accountability Office, *MEDICAID DEMONSTRATION WAIVERS: Approval Process Raises Cost Concerns and Lacks Transparency*, GAO-13-384, June 25, 2013. https://www.gao.gov/products/GAO-13-384

[158] U.S. Government Accountability Office, *MEDICAID DEMONSTRATIONS: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives*, GAO-15-239, April 23, 2015. https://www.gao.gov/products/GAO-15-239

[159] U.S. Government Accountability Office, *MEDICAID DEMONSTRATIONS: More Transparency and Accountability for Approved Spending Are Needed,* GAO-15-715T, June 24, 2015. https://www.gao.gov/products/GAO-15-715T

by various representatives in a separate hearing in July to commemorate 50 years since Medicaid's founding.[160] As such, while arguments are now being made that Medicaid work requirements constitute acting "beyond the scope" of the program's objectives, it is important to note how unclear and easily manipulatable these objectives seem to be.

Due in large part to how vague Medicaid's mandate is, CMS leadership has been able to interpret the mandate as they see fit. In doing so, both the CMS leadership under the Obama Administration and the leadership under the Trump administration have seemingly taken advantage of the broad mandate to further their ideologies regarding the extent to which government should provide support for the poor. While the Obama administration prevented states from attaching TANF-like WCE requirements to Medicaid, a number of states jumped on their opportunity to do so at the suggestion of former CMS Director Brian Neale and Administrator Verma. In Chapter 4, I will return to the insight offered by the Federal Court regarding how the mandate ought to interpreted. Here, I will consider the empirical and normative frameworks that have been used to evaluate the permissibility of attaching WCE requirements to means-tested welfare policies.

IV. Theoretical Frameworks for Understanding TANF

Since Arkansas is the first state to have implemented a Medicaid work requirement, and has done so only within the past sixth months, the bulk of relevant empirical and normative literature on welfare work requirements relates to TANF. In this chapter, I first synthesize the literature on TANF work requirements. I then extend the hypothetical relationships within TANF work requirements to the context of Medicaid. So as not to lose the reader in discussing minutiae of TANF versus Medicaid requirements, I follow the approach of many scholars and use the broader term "welfare work requirements" unless it is

[160] Virgil Dickson, "CMS Fights Claims that Waiver Process is Corrupt and Opaque," *Modern Healthcare,* July 8, 2015. https://www.modernhealthcare.com/article/20150708/NEWS/150709927/cms-fights-claims-that-waiver-process-is-corrupt-and-opaque

of critical importance to distinguish between the two programs. Since both TANF and Medicaid are largely devolved to states, intended to be short-term assurances for low-income Americans, and constitute two overlapping aspects of the United States' "social safety net," I find this broader term to be permissible when synthesizing the studied implications of work requirements on both programs.

The body of literature on welfare work requirements can be divided into two overarching categories: empirical program evaluation and normative analysis. In the following pages, I first survey the central normative arguments surrounding welfare work requirements, focusing on arguments of reciprocity and paternalism. Then, to see how these competing arguments work in practice, I move to empirical evaluations. The empirical evaluations largely focus on whether work requirements are achieving the intended goals of reducing welfare dependency via increasing financial stability among low-income Americans.

A. Reciprocity versus Paternalism

Within the normative literature on welfare work requirements, those who support work requirements largely argue that such requirements are justifiable on grounds of reciprocity, while those opposing work requirements argue that states are implementing such requirements to incentivize what the government deems to be a normatively "good" life, thus constituting paternalistic overreach. I will explore both of these considerations and their more nuanced angles.

Reciprocity

As articulated by Amy Wax in "Something for Nothing: Liberal Justice and Welfare," TANF (and subsequent welfare programs) adopted a normative principle of "conditional reciprocity" when it introduced work requirements for cash benefits (2003). Under this principle, those who receive financial support from the state must be as economically productive as is deemed reasonably possible by the state. This principle effectively makes a distinction between the "deserving" poor (i.e. those who achieve the

state-determined level of adequate economic productivity) and the "undeserving" poor (i.e. those who do not) (Wax, 2003). Conditional reciprocity argues that it is normatively permissible for the government to partially subsidize the deserving poor, who are putting forth good faith efforts to "contribute" to the society that is funding their benefits through taxation; however, the government is under no moral obligation to, and in fact should not, support those who they deem able to contribute but are not (Wax, 2003).

Ethicist Elizabeth Anderson reconstructs this model of societal expectations under what she calls the "general reciprocity principle."[161] While Anderson further couches the principle of general reciprocity in the broader ideology of political conservatism, this framework is beyond the scope of this study. She does, however, draw an important distinction between the "Wide Conservative Reciprocity Principle" (Wide CRP) and the "Narrow Conservative Reciprocity Principle" (Narrow CRP).[162] Wide CRP argues that all state-provided goods to able-bodied citizens should hinge on recipients' paid employment. Narrow CRP says that state-provided means-tested support for low-income citizens should hinge on recipients' paid employment.[163] Anderson assumes that the vast majority of supporters of work requirements for TANF endorse Narrow CRP.

Ultimately, Anderson suggests that the argument for Narrow CRP is fallible for two reasons. First, Narrow CRP fails to be morally permissible because it claims that "only the public support used uniquely by the poor" should be conditional on paid work, while allowing other classes to enjoy state-provided goods or subsidies unconditionally. For example, Anderson cites that

> "Thousands of American farmers receive expensive state subsidies to produce food that is more cheaply and efficiently produced by foreign farmers. Yet we in the U.S. observe no comparable

[161] Elizabeth Anderson, "Welfare, Work Requirements, and Dependent Care," *Journal of Applied Philosophy*, 21, no. 3 (2004): 243
[162] *Ibid., 246*
[163] *Ibid.,* 246

> resentment and contempt directed toward farmers. Far from being stigmatized as welfare dependants, they are lionized as icons of self-reliance."[164]

One could attempt to defend these farmers on grounds that they provide a valuable social good (i.e. their produce) in a way that welfare dependents do not. Implicit in this objection, however, is the reason why both Narrow and Wide CRP: they erroneously presume that societal contributions are restricted only to paid labor, thus excluding such valuable work as unpaid dependent-care.[165] For, surely dependent-care should be considered a valuable social good just as the produce of farmers is considered a valuable social good. But while unpaid caregivers who receive welfare benefits are stigmatized, subsidized farmers are not. While obviously not all welfare dependents are unpaid caregivers, Anderson's two concerns offer important considerations regarding the inconsistencies within the Principle of Reciprocity. Namely, she demonstrates the extent to which we in the United States employ inconsistent standards when appraising the value of social goods and unfairly direct contempt towards those who receive means-tested public assistance. The normative frameworks introduced by both Wax and Anderson have yet to be applied to Medicaid work requirements specifically, and thus have restricted applicability to these work requirements. It seems reasonable to believe that the reciprocity principle may be less defensible when the government-provided good under consideration is not a cash benefit but is instead health care coverage. The ability to achieve a given standard level of health could be portrayed more as a right than cash benefits. My thesis will serve to reconcile whether this difference is philosophically important.

Moral Compulsion and Paternalism

In addition to the demand of reciprocity, some supporters of welfare work requirements believe that the act of depending on government assistance for one's livelihood is morally inferior to working for one's lot. This stance presupposes that to depend on means-tested welfare programs is to reject the

[164] *Ibid.,* 248
[165] *Ibid.,* 246

importance of hard work, personal accountability, and self-reliance.[166] While this argument is significantly less represented in the philosophical literature on work requirements, it continually resurfaces in commonplace political rhetoric in the United States. Such a normative framework is represented in PRWORA, the Personal Responsibility and Work Opportunity Reconciliation Act, which explicitly defines one of its goals as reducing welfare dependency.

Many of those who oppose work requirements do so on grounds that imposing a moral demand on the poor to adopt a strong work ethic is paternalistic. Lawrence Mead argues that the difference between paternalistic social policies and "pre-paternalistic" social policies lies within their diverging goals.[167] The goals of paternalistic social policies are different from pre-paternalistic social policies in two central ways: Paternalistic policies are more concerned with enforcing compliance with certain values and paternalistic policies instill the state with the authority to direct individuals' interests.[168] It is important to note that the values being enforced by paternalistic social policies need not be controversial values, and in fact they rarely are. As Mead points out, hard work and personal responsibility are not morally questionable values to hold; ethical concerns arise when states begin requiring that citizens behave in ways that align with these values, thus requiring that they at least appear to adopt them. Additionally, it is of key concern that paternalistic value enforcement is "directive" in that it does not provide individuals with a real choice of whether or not to adopt these values.[169] Though directive policies may be couched in language around incentives, they force a choice between adopting the desired behavior (i.e., paid work) or else facing real consequences (i.e., revoking state-provided assistance). The distinction between when a policy is incentivizing behavior or when it is forcing a choice remains somewhat unclear. It seems reasonable to deduce from Mead's discussion that if a policy aims to influence behavior through true opportunities and benefits, this would require increasing benefits for those who comply while restraining

[166] Elizabeth Anderson, "Welfare, Work Requirements, and Dependent Care," *Journal of Applied Philosophy*, 21, no. 3 (2004): 249
[167] Lawrence Mead, "Telling the Poor What to Do" *Public Interest,* 132 (Summer, 1998): 97
[168] *Ibid.*
[169] *Ibid.*

from punishing those who do not; however, my thesis will aim to clarify this distinction by using Medicaid work requirements as a philosophical case study.

Anderson (2004) critiques paternalism as an argument for opposing work requirements because she argues that to do so is to cede the premise that the poor, especially those who are not engaged in paid work, have different values than the rest of working society.[170] She takes the argument against paternalistic welfare policies as an insistence that the government remain neutral on conceptions of the good and therefore protect the liberty of the poor to define their individual interests.[171] While Mead's concerns of paternalistic policies revolve around whether or not individuals have a real choice of whether to adopt or reject government-endorsed values, Anderson argues that defending this choice is to allow that the poor face a choice between their own (deviant) values and the (non-deviant) values of work. The disagreement here poses a philosophically interesting question of whether defending one's ability to select one's values remains agnostic about what those values are, or if it assumes that those values are deviant. This consideration will be important in framing a philosophical analysis of Arkansas' Medicaid work requirements.

In his analysis of basic income and cash transfers, Douglas Mackay evaluates the extent to which such policies satisfy the concept of *Welfare State Paternalism* (WSP). According to Mackay, "government A acts paternalistically towards citizen B by implementing welfare policy C if and only if:

1. C aims to improve B's good or well-being;
2. C is implemented without B's consent; and,
3. A's implementation of C is motivated by and/or expresses a negative judgement about B's self-governance or decision-making abilities."[172]

[170] Elizabeth Anderson, "Welfare, Work Requirements, and Dependent Care," *Journal of Applied Philosophy*, 21, no. 3 (2004): 249
[171] *Ibid.*
[172] Douglas Mackay, "Basic Income, Cash Transfers, and Welfare State Paternalism," *The Journal of Political Philosophy* 0, no. 0 (2019): 10.

Mackay makes a point to note that not all welfare policies qualify as WSP. In order for a policy to satisfy this definition, it must be "generally motivated by or express a negative judgment about … recipients' *self-governance abilities.*"[173] Mackay draws a clear distinction between this negative judgement about self-governance ability and "the judgment that recipients lack the *external resources* necessary to secure a certain standard of living."[174] Certain welfare policies could be, and often are, justified by "appeal to the state's duty to meet the basic needs or capabilities of its citizens, to fulfil their human rights, or to secure social equality."[175] As such, fulfilling basic entitlements to citizens via welfare policies "need not be justified by a negative judgment regarding their citizens' self-governance abilities."[176]

Ultimately, the extent of a policy's paternalistic nature hinges on the nature of the judgement motivating the policy as well as the judgement expressed by the policy regarding the population it affects. So, "welfare policies are also paternalistic if governments aim to realize certain outcomes for citizens – for example, outcomes relating to health, nutrition, housing, and happiness– by providing in-kind benefits and services rather than cash, on the grounds that citizens will do worse with respect to these outcomes if given cash, due to their poor judgment."[177] He specifically cites "conditional cash transfers" as an example of a paternalistic policy.[178]

A policy also avoids WSP if the citizens who are subject to the policy consent to it. Mackay emphasizes that in order to consent to a policy, citizens must do more than simply comply with it or accept its associated benefits. "Rather, one must make an explicit act of authorization–that is, give a token of consent."[179] He goes on to say that "it strikes me as reasonable to claim that citizens give a token of consent to a policy when they vote in favor of it in a referendum," "vote for a political representative

[173] *Ibid.*
[174] *Ibid.*
[175] Douglas Mackay, "Basic Income, Cash Transfers, and Welfare State Paternalism," *The Journal of Political Philosophy* 0, no. 0 (2019): 11
[176] *Ibid.*
[177] *Ibid.,* 12.
[178] *Ibid.*
[179] *Ibid.,* 9.

explicitly promising to work to implement it if elected," "writ[e] an op-ed in support it it," or "work[] in other ways to generate popular support for it."[180]

By Mackay's definition, the problem with paternalistic welfare policies is that they "fail to regard their targets as equal autonomous persons and, in so doing, *insult* or *demean* them, affronting their equal dignity."[181] To the degree that its targets are autonomous agents, a paternalistic welfare policy "disrespects" its targets by treating them like children, thus insinuating that they lack the necessary decision making abilities to make wise choices about their lives as autonomous agents.[182] Further, paternalistic policies "undermine the equal status of persons" by insinuating that the "paternalist" has a better judgement of what the target should do and/or how the target should do it.[183] In these two ways, paternalistic welfare policies commit a moral wrong by undervaluing the agency of the targeted autonomous agents. For these reasons, Mackay argues, a policy that satisfies the definition of WSP is pro tanto wrong. That is, there are "degrees" of normative wrongness for a given instance of WSP. Mackay introduces various factors that bear on the degree to which a paternalistic policy is pro tanto wrong. Further, he organizes them around a "horizontal dimension" and a "vertical dimension." The horizontal dimension concerns "the number of people wrong" while the vertical dimension concerns the "intensity of the wrong the policy inflicts."[184]

Along the horizontal dimension, Mackay cites that the wrongness of a policy is higher depending on the "number of people subject to the policy who have authorized it" and "the number of people targeted by the policy who are competent agents as opposed to incompetent agents."[185] Regarding the vertical dimension, Mackay argues that the wrongness of a paternalistic welfare policy hinges on five considerations:

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[180] *Ibid.,* 22.
[181] *Ibid.,* 14.
[182] *Ibid.*
[183] *Ibid.*
[184] Douglas Mackay, "Basic Income, Cash Transfers, and Welfare State Paternalism," *The Journal of Political Philosophy* 0, no. 0 (2019): 18.
[185] *Ibid.*

(1) the target's degree of decision-making capacity;

(2) whether the policy is means or end paternalism;

(3) the policy's degree of singling out;

(4) whether the target population supports or opposes the policy; and

(5) the policy's degree of "autonomy infringement."[186]

Since not every factor that Mackay raises has been measured in the case of Arkansas's WCE requirement, I will draw only on the factors that clearly weigh on the degree to which the requirement is or is not pro-tanto wrong. When I make my final analysis, I will both clarify and elaborate on the considerations that are relevant to my analysis.

Whereas Anderson's and Mead's definitions of paternalism offer a jumping off point for understanding paternalism in broad strokes, Mackay's formulation of WSP offers an explicit and applicable theoretical framework against which to evaluate whether Arkansas' work requirement is ethically impermissible on a charge of paternalism.

B. Empirical Frameworks: Evaluating Means-Tested Welfare

Successes of TANF

Some proponents of the workfare requirements for TANF have lauded the program's success at decreasing welfare caseloads.[187] Between 1996 (when TANF was established) and 2002, the number of families receiving cash benefits dropped from 4.6 million families down to 2.1 million families.[188] One weakness of using a reduction in welfare caseloads as an indicator of success, however, is that individuals who unenroll from means-tested programs may not necessarily be better off than those remained enrolled, and they do not necessarily have a job.

[186] *Ibid.,* 24-25.
[187] Patrice Gains, "Welfare Reform: Is It Working?" *The Crisis,* 114, no. 1 (January/February 2007): 14.
[188] *Ibid.*

Other scholars have used the metric of poverty rates among female-headed families to determine whether TANF and its work requirement has achieved its goals. Haskins (2015), cites that while the proportion of poor families receiving TANF benefits has indeed declined, the percent of female-headed households living in poverty has also declined. Between 1987 and 1993 (under AFDC) the mean poverty rate for female-headed households was 54.3 percent based on earnings alone, and was 41.7 percent based on earnings plus benefits minus taxes.[189] The difference between these two poverty rates (23.2 percent) indicates the extent to which AFDC's "work-support system" ameliorated poverty between those years. Haskins, and similar scholars, loosely define the work-support system to include the Supplemental Nutrition Assistance Program (SNAP), the Earned Income Tax Credit (EITC) for poor families with children, and Medicaid.[190] Though the Great Recession resulted in poverty rates to fluctuate in the years following the introduction of TANF, both of these metrics of poverty among female-headed households have dropped significantly. As of 2013, the poverty rate among female-headed households was 47.6 percent based on earnings alone, and 29.2 percent based on earnings plus benefits after taxes.[191] The overall reduction in poverty for female-headed households may point to successfully incentivizing single mothers to support themselves financially.[192] Moreover, between 1993 and 2013, the difference between the poverty rates with and without accounting for TANF's work supports has grown from 23.2 percent to 38.7 percent.[193] This increased gap suggests that TANF's work-support system is reducing poverty more than the benefits under AFDC were, but Haskins does not address how these work-supports are reducing these poverty rates.

Shortcomings of TANF

[189] Ron Haskins, "TANF At Age 20: Work Still Works," *Journal of Policy Analysis and Management* 00, no. 0, 1–8 (2015).
[190] *Ibid.*
[191] *Ibid.*
[192] *Ibid.*
[193] *Ibid.*

Using longitudinal data from Wisconsin, political scientist Chi-Fang Wu examines the relationship between the duration, severity, and timing of welfare sanctions and the economic well-being of TANF recipients with children. She finds that, among welfare recipients, those who are currently experiencing welfare sanctions face an increased risk of leaving the program without a job.[194] She also finds that the likelihood of leaving welfare decreases regardless of "post-welfare employment status" when families receive a small sanction, while families facing a large sanction face a higher likelihood of leaving welfare without a job or with a lower paying job than they had while receiving welfare.[195] Wu defines sanctions reducing welfare benefits as a consequence for not meeting work requirements. While I will not be utilizing longitudinal data to evaluate whether Medicaid work requirements result in recipients leaving Medicaid without a job, I will utilize a qualitative approach (discussed in more detail in the following chapter) to explore similar dynamics. Wu's longitudinal data lacks qualitative evidence that may shed further light onto the causal mechanism driving sanctioned welfare recipients to leave welfare without another source of income.

Scholars have also evaluated TANF by looking at recidivism rates among former-recipients to determine the extent to which TANF has helped recipients achieve financial independence. In 2002, scholars Steven Anderson and Brian Gryzlak studied 12 states with large TANF caseloads, finding that recidivism within the first year averaged between 21 and 35 percent within the first year.[196] This same study states that TANF-leavers most often attribute this recidivism to difficulty maintaining or finding a job after leaving the program.[197] In a study that focused on female TANF leavers from inner-city Chicago, authors found that low wages and unstable jobs were the most often cited reasons for returning to the program.[198] Additionally, difficulties obtaining health care and child care, and inconsistencies among

[194] Chi-Fang Wu, "Severity, Timing, and Duration of Welfare Sanctions and the Economic Well-Being of TANF Families with Children," *Children and Youth Services Review* 30 (2008).
[195] *Ibid.*
[196] Steven G. Anderson and Brian M. Gryzlak, "Social Work Advocacy in the Post-TANF Environment: Lessons from Early TANF Research Studies," *Social Work* 47, no. 3 (July 2002).
[197] *Ibid.*
[198] *Ibid.*

TANF caseworkers were also cited as important contributing factors to returning to TANF.[199] While these studies do not compare TANF recidivism rates to AFDC recidivism rates, they do shed light on the shortcomings of TANF regarding the extent to which the program is helping recipients achieve long-term financial independence.

Frances Piven analyzes the effectiveness of TANF work requirements by looking at the terms of work and how work requirements have impacted wages and employee-employer power dynamics. Piven argues that without welfare work requirements, welfare recipients have a choice to live on sub-standard, government-provided income without having to engage in paid work, or to increase their quality of life by engaging in paid work and decreasing their dependency on the state.[200] She refers to this tradeoff as the welfare-work tradeoff, and she argues that the imposition of the work requirement under TANF denies recipients the ability to calculate their own welfare-work tradeoff for themselves.[201] Aside from normative considerations, she argues that denying recipients this calculation has allowed employers of low-wage workers to depress wages and exploit labor. She relies on previous literature that shows that governments providing a benefit-floor has been found to result in higher overall wages.[202] Her analysis suggests that the sanctions imposed by TANF work requirements have lowered the standard of living among means-tested welfare recipients and consequently decreased bargaining power among power workers'.

The extent to which these findings would translate to evaluating Medicaid work requirements are not immediately clear, though they suggest that any weakening of the social safety net may allow employers to exploit labor and maintain poor working conditions for low-paid workers. Under a Medicaid work requirement, enrolled workers risk their access to critical medical services if they leave their job in search of better working conditions or more fulfilling work. This is the fear that the APA expressed in their letter to Administrator Verma, warning that "many of these recipients will be forced to make a

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[199] Steven G. Anderson, Anthony P. Halter, and Brian M. Gryzlak," Difficulties after Leaving TANF: Inner-City Women Talk About Reasons for Returning to Welfare," *Social Work* 49, no. 2 (April 2004): 185.
[200] Frances Fox Piven, "Welfare and Work," *Social Justice* 25, no. 1 (Spring 1998): 67.
[201] *Ibid.*
[202] *Ibid.*

"choice" - either leave a Medicaid program that provides essential treatment and enables the possibility of seeking meaningful employment, or seek low-wage temporary employment that can compromise health and well-being."[203] Regardless of whether employers are intentionally taking advantage of this "choice," there remains a legitimate concern that attaching a WCE requirement to Medicaid will drive employees to remain in jobs that put their mental and physical health in jeopardy.

Within the normative body of literature on work requirements, the main argument in favor of such a requirement rests on a principle of reciprocity that is defined with only subtle differences between Wax and Anderson. The main argument against a work requirement is rooted in a charge of paternalism that renders the policy unjustifiable. When I evaluate the normative permissibility of Arkansas's work requirement later in the paper, I will address whether the policy's justification is permissible on grounds of reciprocity or impermissible on grounds of paternalism. To assess the charge of paternalism in relation to the policy, I will utilize Mackay's framework of WSP. For the purposes of this thesis, I favor the WSP framework because it offers the most comprehensive and applicable definition of paternalism currently available to me.

Empirically, scholars have evaluated the successes of TANF work requirements by using the metrics of number of welfare caseloads and the poverty rates among female-headed households. To measure the policy's shortcomings, scholars have studied recidivism rates, likelihood of leaving TANF without a job, and depressed wages. Below, I will extrapolate the empirical findings from these scholars as I analyze whether Arkansas's Medicaid work requirement is likely to further Medicaid's fundamental objectives.

V. Regulatory Permissibility

In this chapter, I will consider whether federal regulation permits CMS to allow states to withhold Medicaid benefits as a means of encouraging individuals to work. Particularly, I will address two

[203] Clinton Anderson, Ph.D. to Seema Verma, *American Psychological Association,* February 13, 2018.

questions: (1) whether making healthcare benefits contingent on work disappoints Medicaid's fundamental objectives, and (2) whether encouraging workforce participation is beyond the scope of HHS's authority. The urgency of these questions has been mounting even before Arkansas implemented its WCE requirement, particularly due to the class action suit *Stewart et al., v. Azar et al.,* which was filed in January 2018 to challenge Kentucky's own Medicaid WCE requirement.[204] Throughout this chapter, I will use this case as a regulatory touchstone for whether Arkansas's WCE requirement properly follows from federal regulation.

A. Satisfaction of Medicaid's Core Objectives

A number of the policy's opponents have raised the concern that a WCE requirement "subverts" Medicaid's central objectives. To assess this argument, I revisit the complaint expressed by some lawmakers that CMS has failed to specify its objectives. Given this failure, one could argue, hinging Medicaid eligibility on workforce participation or "community engagement" is regulatorily permissible because there is no solid statement of objectives that it goes against.

This objection ultimately fails, however, in light of the information revealed by Judge Boasberg's careful evaluation of Kentucky's work requirement. For this case, the Court was similarly tasked with evaluating whether or not a state's Medicaid work requirement promoted Medicaid's "fundamental" objectives. Judge Boasberg explains that "while the objectives of Section 1115 may be ambiguous, courts have traditionally looked to 42 U.S.C. 1396-1, which provides standing appropriation authority for federal support of "State plans for medical assistance," to discern those objectives."[205] Moreover, Secretary Azar himself agreed that Section 1396-1 offers "the starting point to ascertain the objectives of Medicaid."[206] This provision "explains that Congress appropriated Medicaid funds

[204] Sara Rosenbaum, "*Stewart v. Azar* : Inside The Briefs Filed By Plaintiffs And Their Amici," *Health Affairs Blog,* April 20, 2018. https://www.healthaffairs.org/do/10.1377/hblog20180419.350167/full/
[205] *Stewart v. Azar,* 313 F. Supp. 3d 237 (D.D.C. 2018): 33.
[206] *Ibid.*

> [f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance … [to] individuals[] whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals atttain or retain capability for independence or self-care."[207]

Within this framework, Medicaid does have a set of two fundamental, albeit vague, objectives. It follows from this that in order for a Medicaid program to remain within "reasonable" interpretation of Medicaid's objectives, it must furnish two things: "medical assistance" and "rehabilitation and other services." While "rehabilitation and other services" are attached to the end goal of helping "such individuals" achieve and maintain "capability for independence," it is critical to note that the means of achieving this end must still promote medical coverage for Americans who cannot afford medical services. As such, "th[e] focus on health," which is cited repeatedly throughout Arkansas' work requirement proposal, "is no substitute for considering Medicaid's central concern: covering health costs."[208]

Boasberg further offers an even more damning analysis of the intentions of Medicaid's framers. He argues that even "more fundamentally" than the fact that Congress chose cost-coverage as the intended means for promoting health,

> "promoting health is not the only reason Congress wanted to provide health insurance to needy populations. It also had an interest in making healthcare more affordable to such people … Had Congress maintained a singular focus on promoting health, it easily could have said as much, but the text and structure of medicaid shows its desire to provide health coverage to those groups."[209]

Echoing the sentiment of Judge Boasberg, Vikki Wachino has also argued against the implementation of Medicaid work requirements on grounds that "promoting economic self-sufficiency may be a worthwhile policy goal, but it is not a core objective of the program and should not subvert the

[207] *Ibid.*
[208] *Ibid.,* 44
[209] *Ibid.,* 45

goal of providing health coverage to low-income people."[210] It is on this point that Arkansas's Medicaid work requirement ultimately proves impermissible. Ultimately, the substantive reduction in healthcare coverage renders this condition inconsistent with Medicaid's fundamental purpose to provide healthcare coverage to needy Arkansas citizens. In the six months since implementing the program change, Arkansas Works lost over 18,000 of the 69,000 beneficiaries who did not receive exemption from the work requirement. This number represents a staggering reduction in healthcare coverage, which expressly violates the program's necessary objective of promoting coverage. While it is unclear whether the program will continue dropping beneficiaries at such large volumes, the results of the demonstration up to now show nothing to suggest otherwise. If the number of former beneficiaries is not ultimately restored to comparable pre-requirement levels, the condition of work for receiving Medicaid benefits cannot be said to promote the goal of "furnishing" health care coverage, thus relegating the condition regulatorily impermissible.

B. Scope of CMS Authority

Some opponents of the work requirement maintain that even if the program promoted health care coverage, using a work requirement to achieve this goal is beyond the scope of CMS' authority. On regulatory principle, one could argue, CMS's jurisdiction should be strictly restricted to promoting behavior that is directly related to health. Since experts are still deeply divided on if, and under what conditions, work promotes health, the relationship appears indirect at best. Unfortunately, while this may prove a reasonable argument for changing written regulation to restrict CMS's authority, it is insufficient to show that current regulation places such restrictions on the agency. While Section 1396-1 provides us with a "starting point" from which to define Medicaid's objectives, it does not itself define the limits of these objectives. Strictly speaking in terms of established regulation, the Secretary of HHS can interpret Medicaid's objectives to be as expansive as she or he desires, save for two conditions: This interpretation

[210] Vicki Wachino, "Medicaid Work Requirements Won't Improve Health Outcomes, *The Hill*, January 10, 2018 https://thehill.com/opinion/healthcare/369569-medicaid-work-requirements-wont-improve-health-outcomes

must not fall "outside the bounds of reasonableness" as so described by Judge Boasberg, and this interpretation must not undermine the government's coverage of healthcare and necessary rehabilitation services for low income individuals.[211] As such, a work requirement is not in itself impermissible on regulatory grounds. It is worth noting, however, that in responding to Secretary Azar's "interest in promoting greater independence and reducing reliance on public assistance," Judge Boasberg and the Court "ha[d] doubts whether such an objective is proper" within Medicaid.[212] These doubts suggest a level of discomfort among the judges regarding how CMS, under HHS, is wielding their authority to promote work-related activities; due to the soft language, however, the wariness among the judges is inconclusive as to whether or not a work requirement for Medicaid is truly "proper."

While the permissibility of a Medicaid work requirement holds on an objection to jurisdiction, since Arkansas Works has wrought substantive and unjustified loss of coverage for beneficiaries, the program is ultimately impermissible in that it is fundamentally inconsistent with "Medicaid's text, structure, and legislative history."[213] This inconsistency undermines the essence of the program and thus renders the work requirement principly unjustifiable.

VI. Normative Permissibility

Beyond the question of legality, there is a philosophically important question of whether the state of Arkansas normatively should continue the WCE requirement given conflicting arguments regarding what individuals are or are not entitled and what the government should or should not be expected to provide for its low-income citizens. That is to say, it is valuable to consider whether or not a state *ought* to continue the policy, not merely whether the state is permitted to do so under current regulation. Drawing from the philosophical body of literature introduced in Chapter 4, I will consider both the argument in favor of Arkansas's WCE requirement (as supported by the Principle of Reciprocity) as well as the

[211] *Stewart v. Azar,* 313 F. Supp. 3d 237 (D.D.C. 2018): 51
[212] *Ibid.* 53
[213] *Ibid.* 51

argument against the WCE requirement, namely that it constitutes an unjustifiable instance of welfare state paternalism.

While it may be reasonable to extrapolate the reciprocity argument in favor of TANF's work requirements to Arkansas's work requirement, neither CMS nor other advocates for a Medicaid work requirement have overtly appealed to a principle of reciprocity to justify the policy. For the sake of argument, however, I will entertain the hypothetical argument that Arkansas's work requirement is permissible on grounds that those who receive state provisioned healthcare services have an obligation to contribute to society.

A. Principle of Reciprocity

Under TANF, there is a clearly defined cash transfer to low-income individuals and many of the policy's supporters have argued that if the government (as proxy for society) is going to be *giving* individuals money, then these individuals should be 'paying back' society by contributing to society via workforce participation or community engagement. Implicit in this argument is the claim that individuals are not inherently entitled to a certain level of income; rather, the degree of their deservingness is proportionate to their participation in certain 'acceptable' labor practices (often excluding informal caregiving among others). While the truth value of this claim lies beyond the scope of this paper, I raise the point to emphasize the following: Even if it were true that individuals are not inherently deserving of income, it is far from obvious that we can extend the same reasoning to healthcare. In fact, attempting to similarly map entitlement to healthcare on degree of economic output immediately raises both practical obstacles and ethical concerns. Practically and ethically speaking, it is not clear how one could develop a justifiable methodology for determining the extent to which beneficiaries should 'pay back' or 'earn' government provisioned healthcare benefits.

More importantly though, there are many compelling arguments for universal healthcare as a requirement of justice. If healthcare is a requirement of justice, receiving healthcare coverage is thus exempt from the principle of reciprocity because individuals are inherently justified in expecting coverage

without needing to 'earn' it. I find Norman Daniels's argument for universal healthcare most persuasive. He argues that John Rawls's principle of fair equality of opportunity ought to be extended to universal access to healthcare due to the "the contribution made by health– and derivatively by health care– to the opportunities people can exercise."[214] While I lack the space to go into depth about Rawls's conception of justice as fairness, the relevant assumption we are extracting to support an argument for universal access to healthcare is that we have an obligation to promote and protect equality of opportunity to the greatest extent possible. Daniels helpfully sketches the logic of how this principle supports universal access to healthcare:

1. "Suppose health consists of functioning normally for some appropriate reference class (e.g. a gender specific subgroup) of a species; in effect, health is the absence of significant pathology.

2. Maintaining normal functioning—that is health—makes a significant—if limited—contribution to protecting the range of opportunities individuals can reasonably exercise; departures from normal functioning decrease the range of plans of life we can reasonably choose among to the extent that it diminishes the functionings we can exercise (our capabilities).

3. Various socially controllable factors contribute to maintaining normal functioning in a population and distributing health fairly in it, including traditional public health and medical interventions, as well as the distribution of such social determinants of health as income and wealth, education, and control over life and work.

4. If we have social obligations to protect the opportunity range open to individuals, as some general theories of justice, such as Rawls's justice as fairness, claim, then we have obligations to promote and protect normal functioning for all.

5. Providing universal access to a reasonable array of public health and medical interventions in part meets our social obligation to protect the opportunity range of individuals, though reasonable people may disagree about what is included within such an array of interventions, given resource and technological limits."[215]

[214] Norman Daniels, "Justice and Access to Health Care," *Stanford Encyclopedia of Philosophy*, Last modified October 20, 2017. https://plato.stanford.edu/entries/justice-healthcareaccess/
[215] Norman Daniels, "Justice and Access to Health Care," *Stanford Encyclopedia of Philosophy*, Last modified October 20, 2017. https://plato.stanford.edu/entries/justice-healthcareaccess/

This brief sketch fails to capture the argument's various caveats and related questions of scope and feasibility that extend beyond the issue of furnishing medical services. Even given these constraints, however, I find the main thrust of the argument sufficiently compelling to exempt healthcare coverage from the principle of reciprocity. Further, the US government also seems at least partially committed to an argument for universal access to critical medical service by the committing itself to such laws as the federal Emergency Medical Treatment and Active Labor Act (EMTALA) that Congress passed in 1986 to require "all hospitals that participate in Medicare and their physicians are duty bound to stabilize and provide medical screening examinations for each patient who comes to the facility for emergency care, regardless of the patient's ability to pay."[216] EMTALA and Medicaid are but two examples of how the US government acknowledges its role in providing medical services to those who cannot afford to pay otherwise.

For the sake of further clarity, however, suppose a supporter of Arkansas's Medicaid WCE requirement remains unconvinced. According to this supporter, individuals may have a right to healthcare, but this does not mean that they have a right to government provided healthcare coverage. For this reason, she says, it is ethically permissible to hinge Medicaid benefits on such requirements as work and community engagement.

Upon examination, this objection quickly falls apart for two reasons. First, the US government has long accepted a duty to provide for the fundamental needs of its citizens through its federal welfare policies. By its own lights, the US government has a duty to provide healthcare coverage for those who cannot afford it. This responsibility is demonstrated by the core objectives of Medicaid that I discussed in the previous chapter. Moreover, each time the US government has reauthorized the mandate and budget for Medicaid, it has implicitly reiterated its responsibility to provide subsidized healthcare to its citizens who who cannot afford it otherwise.

[216] June M. McKoy, "Obligation To Provide Services: A Physician-Public Defender Comparison," *AMA Journal of Ethics,* 8, no. 5 (May 2006): 332.

It may also be the case that this supporter is implying a belief that Governor Hutchinson similarly insinuated, which is that if Medicaid beneficiaries lose coverage, they can likely attain private insurance without substantial difficulty. This point, too, quickly fails. For it is clear that if individuals are eligible for Medicaid, it is very likely that their "income and resources are insufficient to meet the costs of necessary medical services."[217] For if this was not the case, why would they have qualified for Medicaid in the first place? Under this understanding, we can assume that if an individual is initially eligible for Medicaid but subsequently loses eligibility for reasons other than an increase in income, then they are not receiving "necessary medical services." Thus, the practical options presented to such individuals are either to complete and report 80+ WCE hours a week, or forego medical services. Despite the possible argument that the policy expresses only the belief that individuals are not inherently entitled to healthcare coverage, it is clear that by presenting recipients only with these restricted options, this policy is implicitly claiming that individuals are not inherently entitled to medical services.

Finally, even if one is still convinced that the principle of reciprocity ought to apply to healthcare coverage, Arkansas' Medicaid work requirement could arguably still be normatively impermissible on grounds that the state of Arkansas is the party that is failing to keep their side of the bargain by asking citizens to pay taxes and then deprive them of the services they're paying into. As such, one could argue that the state is failing beneficiaries on the argument of reciprocity. Take Nannette Ruelle, a beneficiary and recovering addict who received a months-long Medicaid lockout after trying extensively to contact the Arkansas DHS. She is one of dozens of recipients who have publicly lamented the arduous process of trying to even get in contact with DHS after losing coverage. Even though the public agency, is supposed to be charged with serving the public. Ruelle, who served time in prison for her drug involvement and who has since worked extremely hard to conform to a model of 'good citizenship,' emphasizes that she has done her part to do what the government has asked of her and now wants the state to follow through on their responsibilities. "They're getting paid to do their job, but they're not even doing it," she

[217] *Stewart v. Azar,* 313 F. Supp. 3d 237 (D.D.C. 2018): 33.

argues.[218] "I served my time and I'm … a resident of the United States of America, Little Rock, Arkansas. I'm a resident here, and I pay my taxes, which helps pay [DHS], so I would expect something in return. I'm paying you, so I need some help back."[219] I should make clear that I am not claiming that the principle of reciprocity should be applied to healthcare coverage. I maintain that this principle is inappropriate to apply to healthcare coverage because coverage is a requirement of justice. While this type of problem could be addressed through more careful policy design, I include Ruelle's consideration here to further demonstrate how the principle of reciprocity is insufficient to justify Arkansas's particular Medicaid work requirement as normatively permissible.

B. Welfare State Paternalism

At this point, I turn to the question of whether the work requirement constitutes an example of WSP. As a reminder, a policy satisfies the requirements of WSP towards a citizen if it "aims to improve [the citizen's] good or well-being," if it's "implemented without [the citizen's] consent," and if its implementation "is motivated by and/or expresses a negative judgement about [the citizen's] self-governance or decision making abilities" (Mackay, 2019). As I will argue below, Arkansas's Medicaid work requirement satisfies all three pillars of this definition, thus constituting WSP. As such, the policy is pro tanto wrong.

The first pillar of Mackay's definition maps easily on to the public justification of the work requirement. In Gillespie's original proposal, in Verma's letter of approval, and in Governor Hutchinson's repeated press conferences regarding the policy, both the state and federal government have continually cited how this requirement will better the "quality of life" and the "health and well being" of recipients (Gillespie, 2017; Verma, 2018; Hardy, 2018). It is clear from this emphasis that the work requirement aims to improve the well-being of Arkansas Works beneficiaries.

[218] Benjamin Hardy, "Locked out of Medicaid," *Arkansas Times*, November 19, 2018. https://www.arktimes.com/arkansas/when-arkansas-works-doesnt/Content?oid=25890378
[219] *Ibid.*

We can now turn to the complex question of whether Arkansas Works beneficiaries consented to the implementation of a work requirement. I will focus on the possible "tokens of consent" that Mackay introduces in his original WSP framework: voting for the policy via referendum, voting for officials who supported the policy, and publicly promoting the policy through either writing an op-ed or publicly announcing one's support by some other means.

I will focus first on whether Arkansas Works beneficiaries consented to the policy by voting. The Medicaid work requirement was not implemented via referendum (direct authorization), and while this is not strictly necessary to establish consent, the lack thereof makes it more difficult to determine if consent was obtained. Further, the process of designing the work requirement, getting the work requirement approved by the federal government, and implementing the work requirement, all occurred within the realm of state and federal agencies, specifically DHS. As an agency, DHS is led by appointed– not elected– officials, both on the state and federal level. This further removes the degree of consent that Arkansans were able to express regarding the WCE requirement.

Arguably, the point at which Arkansans consented to the policy via voting resides in the election of Governor Hutchinson in 2014 and his re-election in 2018. Earlier I mentioned that Hutchinson appealed to Republican legislators in order to get the Medicaid budget passed, but I should clarify that the legislature was not involved in implementing the work requirement in particular. While it is reasonable to predict that the majority of the Republican held state legislature do support the Medicaid work requirement, their actual involvement in implementing this policy extended only to passing the appropriations bill to fund the budget for the Arkansas DHS Division of Medical Services.[220] Therefore, the relevant voting-related "token of consent" in this case would be electing and reelecting Governor Hutchinson. As such, let us turn to Governor Hutchinson's positions on Medicaid during both his election

[220]"An Act for The Department Of Human Services - Division Of Medical Services Appropriation For The 2018-2019 Fiscal Year," State of Arkansas, Act 241 of Fiscal Session (2018). http://www.arkleg.state.ar.us/assembly/2017/2018F/Acts/Act241.pdf

and re-election campaigns. This will allow us to understand just how clearly he conveyed to voters that a vote for him meant a vote for a Medicaid work requirement.

Asa Hutchinson was originally elected to the Governorship in November of 2014, when Arkansan Republicans were still "bitterly divided" over the mere existence of "the Private Option," otherwise known as Arkansas Works.[221] Throughout his first run, Hutchinson "did a lot of hedging on the issue [of Arkansas Works] during the campaign."[222] Even in the week following the 2014 election, Hutchinson was "ever cautious" to say that "he wouldn't announce his own position" on whether or not to continue the Arkansas Works program "until late January"; he also stated that in the meantime, he would "be studying the policy, but he'll also be keeping an eye on which way the wind is blowing in the legislature."[223] Unlike Hutchinson, Mike Beebe, the Democrat and incumbent in the 2014 gubernatorial race, firmly and outwardly supported maintaining the Private Option, which he re-authorized as Governor shortly before the election. Despite substantive discussion of "the future the Private Option" throughout 2014, none of the gubernatorial candidates of that election cycle raised the question of attaching a work requirement to Medicaid.[224] Because of this, we can not look to Hutchinson's initial election to Governor as a token of public support for a Medicaid work requirement.

Governor Hutchinson was up for reelection in November 2018, just eight months after he announced the Arkansas Works WCE requirement. Given his consistent outward goals throughout 2017 and 2018 to reduce the number of Arkansans on Medicaid, his reelection platform positions on Arkansas Works and on access to healthcare more broadly appear contradictory. On his 2018 campaign website, under "On-Going Priorities," the very first priority listed is healthcare, in which he states, "Even with the success of Arkansas Works, health care remains expensive for many Arkansans. [I] [am] committed to working with the Legislature, the Federal Government, and local communities to lower costs and ensure

[221] Benjamin Hardy and David Ramsey, "The GOP in Charge in Arkansas," *Arkansas Times*, November 13, 2014. https://www.arktimes.com/arkansas/the-gop-in-charge-in-arkansas/Content?oid=3541245
[222] *Ibid.*
[223] *Ibid.*
[224] *Ibid.*

the highest quality of care."[225] Among his "potential strategies for improving availability of quality healthcare," he also suggests "work[ing] with communities to tackle barriers to access such as transportation and technological illiteracy."[226] Despite Phase 2 of the WCE requirement beginning just two months after the gubernatorial election, Hutchinson's platform refrains from commenting on the estimated 45,000 new Arkansans who would soon be required to work and/or engage with the community in order to maintain their healthcare coverage.[227] Moreover, even though "Workforce Training" is listed as his second ongoing priority, he includes no mention of a need for more Arkansas Works beneficiaries to gain employment or participate in community-oriented activities. Rather, his stated concern for Arkansas's workforce is that "Arkansans must have the skills to compete" "for jobs in a global marketplace."[228] In line with this concern, he emphasizes that he is "committed to continuing" his "focus on expanding job skills training services at the secondary and post-secondary level in Arkansas."[229]

Though Hutchinson's ongoing priorities express concern over "expensive" healthcare and the related "barriers to access," his campaign website also has a separate page for his "Past Accomplishments" that includes Hutchinson's "healthcare reforms" to reduce the number of Arkansans on Medicaid. Here, the site states that "Hutchinson, his "staff, and DHS worked hard to reform … Arkansas Works" because he "knew that Medicaid, including the optional Medicaid expansion for adults under the ACA, was … growing too fast."[230] Hutchinson explicitly lists "Work Requirements" as one of the "key changes" to the "Arkansas Works waiver.[231] To add to the confusion, he also claims to have "lower[ed] income eligibility from 138% FPL to 100% FPL," predicting that this change "will result in

[225] Asa for Arkansas, "On-Going Priorities," Accessed March 11, 2019. https://www.asa2018.com/on-going-priorities/
[226] *Ibid.*
[227] Benjamin Hardy, "Medicaid work requirement grows to include younger beneficiaries," *Arkansas Times*, February 15, 2019. https://www.arktimes.com/ArkansasBlog/archives/2019/02/15/medicaid-work-requirement-grows-to-include-younger-beneficiaries
[228] Asa for Arkansas, "On-Going Priorities," Accessed March 11, 2019. https://www.asa2018.com/on-going-priorities/
[229] *Ibid.*
[230] Asa for Arkansas, "Accomplishments: Healthcare Reform: Arkansas Works," Accessed March 9, 2019. https://www.asa2018.com/accomplishments/#healthcare
[231] *Ibid.*

approximately 60,000 fewer Arkansans on the Medicaid rolls."[232] If we reflect on the policy context of the WCE requirement, however, we should recall that CMS deferred its decision on the Section 1115 waiver amendment to lower income eligibility for Medicaid and has still not approved it. Regardless, Hutchinson maintains that these reforms "clearly demonstrated" his "commitment to getting Medicaid on a sustainable path" and that he strongly desires to "continue identifying and advancing reforms to achieve that end."[233]

Though his 2018 platform itself may have been contradictory and confusing, voters could have learned Hutchinson's policy positions on healthcare from following the considerable local and national coverage of the WCE requirement. Indeed, it is notable that after eight months since announcing the Arkansas Works WCE requirement, Hutchinson won his re-election campaign with 65.3% of the vote.[234] The Democratic candidate received 31.8% of the vote and the Libertarian candidate received 2.9% of the vote.[235]

Given his re-election, one might argue that the citizens of Arkansas consented to the WCE requirement by re-electing Governor Hutchinson after he passed and stood behind the work requirement. It is reasonable to assume that at least one Arkansas Works beneficiary who is subject to the WCE requirement did not vote for Governor Hutchinson. This satisfies the WSP requirement that the policy was implemented without the consent of at least one person who is subject to it. Regarding the degree to which the state failed to obtain consent for the requirement via voting, I will explore this question in more depth in following the following section.

In addition to voting, beneficiaries could have consented to the policy by publishing op-eds or otherwise promoting support for the policy. In looking for tokens of consent of this sort towards the WCE requirement, I was unable to attain a single op-ed that was written by a beneficiary on the requirement.

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[232] *Ibid.*
[233] Asa for Arkansas, "Accomplishments: Healthcare Reform: Arkansas Works," Accessed March 9, 2019. https://www.asa2018.com/accomplishments/#healthcare
[234] Ballotpedia, "Asa Hutchinson," Accessed March 12, 2019. https://ballotpedia.org/Asa_Hutchinson
[235] *Ibid.*

There are multiple practical considerations, such as lack of free time, access to a computer, or literacy, which may have restricted beneficiaries' ability and/or willingness to write their own opinion piece. The legitimacy of these constraints, however, does not change the fact that the state has not attained "actual" consent from beneficiaries.

In addition to an absence of consent, it remains concerning that a number of enrollees report being unaware of the new requirement.[236] Even among enrollees who have said they were notified about the requirement, the large majority report that they did not "understand the new work or reporting requirements or the consequences of failure to comply, including coverage loss for the remainder of the year."[237] This lack of awareness and understanding among beneficiaries suggest that enrollees have been in no position to provide consent to the new requirements.

By and large, Arkansas Works beneficiaries have not offered the tokens of consent that would necessary to claim that beneficiaries authorized the WCE requirement. Beneficiaries have consented through neither voting nor mobilizing support. Rather, the majority have remained confused by or largely unaware of the policy and its consequences.

The final consideration in determining whether the Arkansas Works WCE requirement is an instance of WSP concerns whether the policy was either motivated by or expresses a negative judgement about beneficiaries' self-governance. In this regard, the WCE requirement is clearly motivated by the judgement that beneficiaries lack the self-governance necessary to gain and maintain employment without the threat of coercive action. This is exemplified by Seema Verma's justification for approving the WCE requirement. Verma explicitly notes that the first iteration of Arkansas Works, which included only voluntary referrals to DWS, has proved itself not to be "an effective incentive."[238] She then rationalizes

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[236] Margot Sanger-Katz, "One Big Problem With Medicaid Work Requirement: People Are Unaware It Exists," *New York Times*, September 24, 2018. https://www.nytimes.com/2018/09/24/upshot/one-big-problem-with-medicaid-work-requirement-people-are-unaware-it-exists.html

[237] MaryBeth Musumeci, Robin Rudowitz, and Barbara Lyons, "Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees," *Kaiser Family Foundation,* December 18, 2018. https://www.kff.org/report-section/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees-issue-brief/

[238] Seema Verma, MPH to Cindy Gillespie, "Approving Arkansas's request," March 5, 2018, 4.

the WCE requirement by arguing that the poor rates of follow-through on behalf of beneficiaries "suggest[]" that "the stronger incentive model" may be "more effective in encouraging participation" in work and community engagement.[239] Verma's justification sufficiently demonstrates that the policy was motivated by the judgement that beneficiaries lack the faculties necessary to govern their employment decisions without a system of rewards and punishments imposed by the state. As such, the policy treats adult Arkansas Works beneficiaries like children despite the fact that they are "equal autonomous persons."[240]

From these considerations, I conclude that the Arkansas Works WCE requirement indeed constitutes an instance of welfare state paternalism. The policy, which explicitly aims to promote higher quality of life among Arkansas Works beneficiaries, was not consented to be the individuals it affects and expresses a clear judgement that these beneficiaries, who are competent agents, are unable to make wise decisions about their own lives. Having established the requirement as paternalistic, I consider the extent of the wrong committed by this instance of paternalism. The extent of the wrong, when weighed against the net benefits the policy produces for beneficiaries, will ultimately determine whether or not the policy is normatively justifiable.

Degree of Wrongness

With all three pillars of Mackay's definition of WSP satisfied, I conclude that the Arkansas Works WCE requirement is an example of WSP and is therefore pro tanto wrong. But how wrong is it? To answer to this question we must evaluate the policy with respect to the factors that bear on the pro tanto wrongness of paternalistic welfare policies. I will look at each factor in turn and determine the extent to which the policy has wronged those subject to it.

[239] *Ibid.,* 5.
[240] Douglas Mackay, "Basic Income, Cash Transfers, and Welfare State Paternalism," *The Journal of Political Philosophy* 0, no. 0 (2019): 14.

Along the horizontal dimension, we return to the question of how many of the individuals subject to the policy actually consented to the policy. I have established the numerous obstacles to determining whether beneficiaries actually consented to the policy by voting for Governor Hutchinson. Another consideration is an equally difficult question of how many beneficiaries likely voted for him. We can attempt to approximate this answer by looking to the economic profiles of those within the electorate who most likely voted for Hutchinson's re-election. This is important given the "means-tested" nature of Arkansas Works eligibility. Since the Medicaid work requirement only applies to individuals within a small subset of income levels, it could very well be the case that the citizens who consented to this policy are not the citizens to whom this policy applies. Since there is likely at least some overlap, the degree to which the state obtained consent depends on the degree to which Arkansas Works beneficiaries voted for Governor Hutchinson.

To explore the legitimacy of this concern, we should get a clearer idea of who cast votes in the 2018 election, who was likely to have casted a vote for Governor Hutchinson, and if this population is representative of Arkansas Works beneficiaries. Importantly, in the 2018 election, voter turnout within Arkansas was only 50.38%.[241] This means that nearly half of Arkansas citizens expressed neither approval nor disapproval of Hutchinson and the policies he supported. The income distribution of Arkansas voters who participated in the 2018 election is not currently available, but I find it reasonable to use party identification as a proxy.[242] In 2014, among adult Arkansans who identified as Republican or lean Republican, 69% had an annual income greater than $30,000, far above the eligibility cutoff for Arkansas Works.[243] Also in 2014, the median household income for voting-eligible Arkansans was

[241] Scytl, "Arkansas 2018 General Election and Nonpartisan Judicial Runoff Official Results," Last modified December 3, 2018. https://results.enr.clarityelections.com/AR/92174/Web02-state.216038/#/

[242] I find this proxy justifiable based on research that indicates that, in general elections, nearly half of Republicans "usually" vote for the candidate that shares their party affiliation, and over one third of Republicans "always" vote for the candidate that shares their party affiliation.

[243] Pew Research Center, "Party affiliation among adults in Arkansas," 2014. https://www.pewforum.org/religious-landscape-study/state/arkansas/party-affiliation/#demographic-information

$41,262, with 16.5% of the electorate falling below the federal poverty line.[244] While none of this voter and party-affiliate information allows us to conclusively claim that the citizens who authorized this program are different citizens than citizens affected by it, I find it reasonable to speculate that a substantive number of Arkansas Works beneficiaries likely did not vote to re-elect Governor Hutchinson and thus, at least with respect to voting, did not consent to the WCE requirement in his platform. Insofar as this is true, the work requirement constitutes a more severe wrong. Indeed, *Gresham et al. v. Azar et al.* corroborates the lack of consent in the accusation that CMS "bypass[ed] the legislative process and act[ed] unilaterally to fundamentally transform Medicaid."[245]

For the second consideration along the horizontal dimension, we are tasked with determining the extent to which subject enrollees "are competent agents as opposed to incompetent agents" (Mackay, 2019). Two crucial considerations here are that the WCE requirement applies only to adults and it exempts all adults who have a severe enough disability as to be deemed physically or mentally unable to meet the requirement. In light of these restrictions, I find it reasonable to deem all enrollees who are subject to the requirement as competent agents. While requiring disabled enrollees to comply with the WCE requirement would introduce additional normative concerns, the fact that all subject enrollees are competent agents significantly increases the wrongness of the policy by "increasing the number of competent agents who are subject to it."[246] Moreover, by explicitly excluding children and individuals with severe disability, DHS seems to have intentionally designed this policy to be directed specifically at competent agents. This intentionality is further suggested by many of the public comments made in defense of the policy. Governor Hutchinson and Seema Verma have continually emphasized individual responsibility as a central tenet of the WCE requirement, seemingly acknowledging that the target

[244] U.S. Census Bureau, "Electorate Profile: Arkansas. Selected Characteristics of the Voting-Age Population." 2014. Accessed March 1, 2019. https://www.census.gov/content/dam/Census/library/visualizations/2016/comm/cb16-tps18_graphic_voting_arkansas.jpg
[245] Gresham et al. v. Azar et al., Civil Action No. 1:18-cv-01900, 2 (2018)
[246] Douglas Mackay, "Basic Income, Cash Transfers, and Welfare State Paternalism," *The Journal of Political Philosophy* 0, no. 0 (2019): 18.

population of this policy is one of competent agents. As such, the WCE requirement is additionally wrong in that its subject population competent.

Now let us consider the pro-tanto wrongness of the WCE requirement regarding the intensity of the wrong committed against those who did not consent to the policy. The factors at point here are the following: the degree of competence among subjected individuals, the degree to which the policy enforces a value that beneficiaries do not share, the degree to which the policy singles out certain competent agents as being deficient in their decision making, the extent of support for the policy among beneficiaries, and the degree to which the policy infringes on beneficiaries autonomy rights.

I will begin by determining the degree of competence among subjected individuals. While it was relatively straightforward to determine how many Arkansas Works beneficiaries are competent, as opposed to incompetent, it is more difficult to determine "the decision-making capacity" of beneficiaries "with respect to the choices in question," in this case, employment and community engagement (Mackay, 2019). The decision-making capacity of beneficiaries regarding their employment could be hindered by lack of education or addiction, but the degree to which this is true is difficult to determine conclusively. There is some research to indicate that individuals in poverty are less able to make well-considered decisions due to the stresses of living with too little.[247] In this regard, we cannot determine the degree to which this increases the wrongness of the WCE requirement.

The second factor along the vertical dimension is the degree to which the requirement "concerns" enrollees' "goals or values" as opposed to "just the means [they] choose to realize their goals or values."[248] In this regard, the WCE requirement has a higher degree of pro tanto wrongness insofar as it furthers goals that targeted individuals do not share.[249] With no statewide opinion polling data available as of yet, we cannot conclusively determine the extent to which Arkansas Works beneficiaries share the goal

[247] Sendhil Mullainathan and Eldar Shafir, *Scarcity: Why Having Too Little Means So Much* (Allen Lane, 2013).
[248] Douglas Mackay, "Basic Income, Cash Transfers, and Welfare State Paternalism," *The Journal of Political Philosophy* 0, no. 0 (2019): 20.
[249] *Ibid.*

of maintaining employment. Anecdotally and as found within focus groups, many beneficiaries fail to comply with the requirement, not because they oppose working, but because they have significant health problems that prevent them from working, they perform work that does not comply with the nuanced reporting-hours standards, or they struggled to report hours of eligible work they performed.[250] Many complain that the WCE requirement actually makes it more difficult to "pay the bills" or that they are already trying to accomplish the goals that DHS is attempting to impose on them.[251] These sentiments suggest that many subject enrollees do share the value of financial self-sufficiency, indicating that the policy's wrongness is less than it would be if it was imposing a value that recipients did not share.

It is difficult to derive the extent to which the requirement "single[s] out" Arkansas Works beneficiaries "as being deficient in their decision making," since the requirement applies to all Arkansas Works beneficiaries, but beneficiaries themselves are at the bottom of the socioeconomic ladder. A supporter of the WCE requirement might say (and in fact, a cheeky article headline did say) that enrollees can receive healthcare coverage just like everyone else, "but first, get a job."[252] But within this statement is an implicit declaration that those who work (and, by proxy, those who are wealthier) are making the right choices in their lives and are thus more worthy of healthcare benefits. In fact, DHS will exempt enrollees from the requirement so long as they have a monthly income that is greater than or equal to 80 hours of work at Arkansas's minimum wage. Because of this, someone could work for very little, so long as their hours of work paid very well. This would suggest that this policy is targeting those working lower paid jobs, thus increasing its wrongness.

I turn now to the degree of support among enrollees for the requirement. In distinguishing between "consent" for a policy and "support" for a policy, Mackay states that, "When governments implement a policy that is *supported* by the targeted population, they do not secure citizens' actual

[250] Benjamin Hardy, "Locked out of Medicaid," *Arkansas Times*, November 19, 2018. https://www.arktimes.com/arkansas/when-arkansas-works-doesnt/Content?oid=25890378
[251] *Ibid.*
[252] Benjamin Hardy, "First, get a job: Arkansas's Medicaid work requirements begin," *Arkansas Times*, June 14, 2018. https://www.arktimes.com/arkansas/first-get-a-job/Content?oid=19088707

consent to the policy, but they do secure citizens' hypothetical consent – that is, it is a policy to which citizens would consent if asked to explicitly authorize it."[253] Ideally, I would draw upon opinion polling of Arkansas Works beneficiaries regarding their degree of support or opposition to the WCE requirement. Due to a lack of such polling, however, I cannot yet determine the sentiments among subject beneficiaries towards the requirement. In place of survey data, I reiterate the anecdotal evidence from both the newspaper interviews and the plaintiffs of *Gresham et al. v. Azar et al.* that I discussed in Chapter 2. Every beneficiary who has publicly discussed their experience with the Arkansas Works WCE requirement has expressed opposition to it.[254] Beneficiaries' opposition to the requirement ranges from finding the requirement patronizing to experiencing visceral panic at the risk of losing healthcare coverage.[255] A number of beneficiaries are not simply disgruntled or inconvenienced by this policy, they are literally fearful for their lives.[256]

The researchers from Kaiser Family Foundation have gathered further insights on beneficiary sentiments from the two focus groups they conducted with Arkansas Works beneficiaries. With one focus group in urban Little Rock and one in rural Monticello, the researchers found that the WCE requirements "are adding anxiety and stress to enrollees' lives."[257] These findings reinforce the sentiments expressed by the plaintiffs, all of whom reported that the WCE requirement negatively impacted either their physical or mental wellbeing, if not both.[258] From the sentiments expressed by beneficiaries anecdotally and in the courts, I find sufficient evidence to conclude that Arkansas Works beneficiaries do not support the work requirement. To the degree that the current anecdotal evidence reflects the general sentiment among the majority of beneficiaries, this lack of support further deepens the wrong committed by the requirement.

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[253] Douglas Mackay, "Basic Income, Cash Transfers, and Welfare State Paternalism," *The Journal of Political Philosophy* 0, no. 0 (2019): 22.
[254] See Chapter 2 for detailed discussion of beneficiary experiences and complaints.
[255] Such as plaintiff Ms. Cardon
[256] See Charles Gresham's comments on discussing the policy with his therapist (p. 22).
[257] MaryBeth Musumeci, Robin Rudowitz, and Barbara Lyons, "Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees," *Kaiser Family Foundation,* December 18, 2018. https://www.kff.org/report-section/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees-issue-brief/
[258] Gresham et al. v. Azar et al., Civil Action No. 1:18-cv-01900, 35 (2018)

Here, it is centrally important to determine the degree to which the WCE requirement "infringe[s]" on the "autonomy rights" of Arkansas Works beneficiaries. As Mackay discusses, one way to infringe on individuals' autonomy rights is "by limiting the choices they are entitled to make."[259] He illustrates his point by considering SNAP's own WCE requirement. If we assume that all citizens of the United States have a "right to food," and that the US government has a "duty to fulfill this right," then requiring SNAP recipients to work as a condition of SNAP benefits appears to be coercive in that this condition restricts the choices that recipients are entitled to make about their own lives.[260] This logic can easily apply to the case of Medicaid work requirements, in which recipients are required to work in order to access government-provisioned healthcare coverage. If we accept as true that all US citizens have a right to healthcare coverage, and that the US government has a duty to fulfill this right, then "attaching a sanction to the choice" of not working, volunteering, or receiving an education for at least 80 hours a month is a form of coercion.[261]

As I have argued earlier in this paper, I believe that both of these premises are true. I take as true that the US government has a duty of justice to ensure universal healthcare coverage. Further, by provisioning services for low-income families for over fifty years, the federal government seems to have at least partially acknowledged its responsibility to fulfill this right. Moreover, the extent of coercion under the WCE requirement is considerable due to the severity of the sanction. The sanction against the choice not to work could range from harmful to fatal for individuals who need critical medical services but are locked out of coverage. Indeed, as evidenced by the plaintiffs of *Gresham v. Azar,* many beneficiaries who lost coverage due to the WCE requirement have not been able to afford the uninsured out-of-pocket expenses for critical medications and/or visits to the doctor.[262] As a result, many have gone without these necessary services.[263]

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[259] Douglas Mackay, "Basic Income, Cash Transfers, and Welfare State Paternalism," *The Journal of Political Philosophy* 0, no. 0 (2019): 23.
[260] *Ibid.*
[261] *Ibid.*
[262] Gresham et al. v. Azar et al., Civil Action No. 1:18-cv-01900, 35 (2018)
[263] *Ibid.*

Unfortunately, there is no quantitative, determinate degree of wrongness that one can assign to a paternalistic welfare policy. To fabricate one would likely prove arbitrary. Even without this conclusive measure, however, it is clear that the wrong committed by the WCE requirement is very severe. By restricting the population of subject enrollees to non-disabled adults, policymakers explicitly aimed to target the requirement at competent agents. At the same time that CMS and Governor Hutchinson seemingly failed to acquire consent from beneficiaries, a number of affected individuals have expressed their opposition to the requirement. Moreover, the requirement constitutes a coercive measure that infringes upon the decisions that individuals are entitled to make regarding their healthcare and whether or not to work.

Is Arkansas's WCE requirement justifiable?

Since paternalistic welfare policies are pro-tanto wrong, the WCE requirement might still be normatively permissible if it produces benefits that are vast enough to outweigh the wrong it commits. If, say, the requirement produced amazing health outcomes among Arkansas Works enrollees, one could argue that the good achieved by the policy sufficiently justifies it. In light of how severely the WCE requirement wrongs so many individuals, however, the bar is set understandably high for the requisite health benefits. This scenario does not hold in the case of Arkansas's Medicaid work requirement, however, in light the very poor outcomes it has produced thus far.

In the nine months since implementing the requirement, 18,164 individuals have lost healthcare coverage after failing to comply with the WCE reporting requirement. This figure suggests that Arkansas DHS has revoked health care coverage from nearly 1 in 4 subject enrollees, the majority of whom have had to go multiple months without coverage due to the lockout. Many have also noted that even this number likely fails to capture the extent of coverage loss, since thousands of others have lost coverage due to "failure to return requested information."[264] Despite the startlingly high rates of coverage loss, this

[264] Arkansas Department of Human Services, *Arkansas Works Program: February 2019*

trend is likely to deepen. On January 1, 2019, DHS implemented "Phase 2" of the requirement to include approximately 45,000 subject beneficiaries who are between the ages of 19 and 29.[265] By significantly increasing the number of individuals who are subject to the requirement, Phase 2 of the policy also significantly increases the number of agents wronged by the policy, thus increasing its degree of pro tanto wrongness. Starting April 1, 2019, non-exempt beneficiaries who fail to comply with the requirement will again begin losing coverage, and as of March 7, 2019, 6,472 enrollees have already failed to meet the requirement for two months.[266] This figure suggests that the trend of non-compliance seen in 2018 will likely continue, now with even more individuals losing coverage for an even more extended amount of time.

Research further suggests that hinging healthcare benefits on employment likely won't achieve work requirement's goal to promote health among beneficiaries. A 2004 study found an association between temporary employment and "psychological morbidity," and these results were bolstered by a 2010 longitudinal study that found that "perceived job insecurity can lead to adverse health effects in both permanent and temporary employees".[267] Unlike the studies referenced by Ms. Verma and Ms. Gillespie, these studies importantly consider how the "psychosocial quality" of the work performed ("levels of control, demands and complexity, job insecurity, and unfair pay[268]") impacts the relationship between employment and health outcomes.[269] Given the low-income status that is necessary to be eligible for Arkansas Works benefits, it is likely that because of the work requirement, many beneficiaries will be entering positions that will hinder their psychological and physical health.

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[265] Benjamin Hardy, "Medicaid work requirement grows to include younger beneficiaries," *Arkansas Times*, February 15, 2019. https://www.arktimes.com/ArkansasBlog/archives/2019/02/15/medicaid-work-requirement-grows-to-include-younger-beneficiaries

[266] Arkansas Department of Human Services, *Arkansas Works Program: February 2019*

[267] Peter Butterworth, L S Leach, L Strazdins, S C Olesen, B Rodgers, D H Broom,"The Psychosocial Quality of Work Determines Whether Employment Has Benefits for Mental Health: Results from a Longitudinal National Household Panel Survey," *Occup Environ Med* 68 (2011): 806.

[268] *Ibid.*

[269] *Ibid.*

With respect to the WCE requirement, the central normative and regulatory concerns relate to furnishing health care coverage. As such, very little of the policy's justification depends on how successfully the policy increases employment. It is notable that multiple reports from the Center on Budget and Policy Priorities have found that Medicaid work requirements, including Arkansas's, fail to "increase employment," "improve health outcomes," or reduce poverty.[270][271] These findings are confirmed by survey results of new enrolled Medicaid beneficiaries who became eligible under Medicaid expansion. In Michigan, "69 percent of those who had jobs said they did better at work once they had health insurance," while "55 percent of those who were out of work said the coverage made them better able to look for a job."[272] Similar results were found in Montana.[273][274] These results suggest that the WCE requirement is not only failing to produce the remarkable health outcomes necessary to justify its implementation, but it is also likely to fail even in regards to promoting employment. Ultimately, the Arkansas Works WCE requirement is normatively unjustifiable in that the severity and breadth of the wrong committed via the policy's paternalism significantly outweighs the benefits it produces.

[270] Judith Solomon, "Medicaid Work Requirements Can't Be Fixed: Unintended Consequences Are Inevitable Result," *Center on Budget and Policy Priorities,* January 10, 2019. https://www.cbpp.org/sites/default/files/atoms/files/1-10-19health.pdf
[271] LaDonna Pavetti, "Work Requirements Don't Cut Poverty, Evidence Shows," *Center on Budget and Policy Priorities,* Last modified June 7, 2016. https://www.cbpp.org/sites/default/files/atoms/files/6-6-16pov3.pdf
[272] Susan D. Goold and Jeffrey Kullgren, "Report on the 2016 Healthy Michigan Voices Enrollee Survey," *University of Michigan Institute for Healthcare Policy & Innovation*. January 17, 2018. https://www.michigan.gov/documents/mdhhs/2016_Healthy_Michigan_Voices_Enrollee_Survey_-_Report__Appendices_1.17.18_final_618161_7.pdf
[273]Bureau of Business and Economic Research, "The Economic Impact of Medicaid Expansion in Montana." *University of Montana*, April 2018. https://mthcf.org/wp-content/uploads/2018/04/BBER-MT-Medicaid-Expansion-Report_4.11.18.pdf
[274] Larisa Antonisse and Rachel Garfield, "The Relationship Between Work and Health: Findings from a Literature Review." *Kaiser Family Foundation*, August 7, 2018. https://www.kff.org/report-section/the-relationship-between-work-and-health-findings-from-a-literature-review-issue-brief/#endnote_link_264795-18

VII. Conclusion

In this thesis, I set out to answer the questions of whether a Medicaid WCE requirement is (1) legally permissible under existing regulation and/or (2) normatively permissible. After close analysis, I find that the Arkansas Works WCE requirement fails to be in line with federal regulation in that it fails to promote Medicaid's objective to provision healthcare coverage for low-income individuals. This conclusion does not, however, preclude the regulatory permissibility of other states' WCE requirements. For, Medicaid's mandate does not limit the scope of authority for HHS, and therefore CMS, to encourage behavior that the agency believes will better the health and wellbeing of beneficiaries. It does, however, require that all measures taken by the agency to promote health must wellbeing must do so without compromising the objective to furnish healthcare coverage.

Further, this requirement is not normatively justifiable because of its degree of paternalism. The population that the policy targets is explicitly intended to comprise individuals who are competent enough to participate in work or community engagement activities, and yet the state has deemed them not competent enough to make decisions regarding whether or not to work. When Arkansans elected Governor Hutchinson, they had no way of knowing that a vote for Hutchinson would be a vote for a Medicaid work requirement. Further, not only did beneficiaries fail to offer a token of consent to the requirement via voting, a number of them have expressed either confusion or explicit disapproval of the policy. Given the lack of impressive health benefits that would be necessary to justify the wrongness of Arkansas's WCE requirement, the policy is normatively impermissible.

Critically, my conclusion regarding the Arkansas Works WCE requirement depends heavily on the empirical outcomes of the policy, thus restricting its application to other instances in which a WCE requirement is attached to Medicaid. For instance, if the individuals who are affected by the policy explicitly consent to hinging their healthcare benefits on workforce participation, this lifts the charge of welfare state paternalism altogether. While this scenario seems highly unlikely, it is more likely that the degree of a WCE requirement's wrongness is more or less severe depending on how many competent

agents it affects, the degree to which beneficiaries support the policy, and so on. Moreover, if a WCE requirement does commit a comparable wrong but manages to produce dazzling health benefits for its target population, there is a chance that the requirement would be permissible on balance. This is to say that, while the apparent intentions behind WCE requirements pose significant and legitimate threats regarding low-income individuals' right to healthcare, such programs should be evaluated on a case-by-case basis, in light of their unique outcomes.

Going forward, I recommend that Arkansas DHS cease implementation of its Arkansas Works WCE requirement. Moreover, in light of the many reports of misunderstanding and lack of information on behalf of affected beneficiaries, the state ought to conduct extensive outreach to individuals who were dropped from coverage to inform them of reinstated coverage. Finally, in order to better understand the mechanisms driving the staggering reductions in enrollment, the state should also survey affected individuals to inquire the specific reasons why the individual failed to comply and/or why they failed to re-enroll, their degree of support for the policy, and how the policy impacted their mental and physical health. This survey data will provide a better foundation of knowledge regarding the ways in which coercive measures such as these impact the lives of their target population. Moreover, this survey data should be utilized for future research on the circumstances in which welfare-required employment improves an individual's health and wellbeing and the circumstances in which welfare-required employment hinders an individual's wellbeing. Until this survey data is collected and analyzed, CMS should withhold from approving any further Section 1115 WCE demonstrations and should require all relevant states to pause implementation. Following this, CMS should re-evaluate each state's policy on a case by case basis. The cost of this experiment has proved too great for WCE requirements to continue until further research has been conducted on how likely each policy is to adequately furnish healthcare coverage. For Medicaid work requirements programs whose outcomes already suggest substantial drops

in healthcare coverage, implementation should be paused, if not ceased, unless measures are put in place to satisfy the objective of Medicaid to promote healthcare coverage among low-income individuals.[275]

[275] Given Governor Hutchinson's outward desire to reduce Medicaid rolls, I am confident that Arkansas is not prepared to put such measures in place, thus corroborating my conclusion that this policy should be ceased.

References

Anderson, Steven and Brian Gryzlak. "Social Work Advocacy in the Post-TANF environment: Lessons from Early TANF Research Studies." *Social Work*, 47, no. 3 (July 2002): 302-314.

Anderson, Steven G., Anthony P. Halter, and Brian M. Gryzlak," Difficulties after Leaving TANF: Inner-City Women Talk About Reasons for Returning to Welfare," *Social Work* 49, no. 2 (April 2004): 185-194.

Antonisse, Larisa, and Rachel Garfield. "The Relationship Between Work and Health: Findings from a Literature Review." Kaiser Family Foundation. August 7, 2018. https://www.kff.org/report-section/the-relationship-between-work-and-health-findings-from-a-literature-review-issue-brief/#endnote_link_264795-18

Arkansas Department of Human Services. *Arkansas Works Quarterly Report April 1, 2018 – June 30, 2018*. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-qtrly-rpt-apr-jun-2018.pdf

Arkansas Department of Human Services. *Arkansas Works Work and Community Engagement Requirements.* August 2018. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-cmmnty-engagement-draft-eval-dsgn-20180813.pdf

Arkansas Senate. *Amendment No. 1 to Senate Bill 30*. 91st General Assembly, 2018, serial LCW084. http://www.arkleg.state.ar.us/assembly/2017/2018F/Amendments/SB30-S1.pdf

Asa for Arkansas. "Accomplishments." Accessed March 9, 2019. https://www.asa2018.com/accomplishments/

Asa for Arkansas. "Accomplishments: Healthcare Reform: Arkansas Works." Accessed March 9, 2019. https://www.asa2018.com/accomplishments/#healthcare

Asa for Arkansas. "On-Going Priorities."Accessed March 11, 2019. https://www.asa2018.com/on-going-priorities/

Beam, Adam. "Trump administration approves Kentucky's Medicaid work requirement waiver." *PBS.* November 21, 2018. https://www.pbs.org/newshour/health/trump-administration-approves-kentuckys-medicaid-work-requirement-waiver

Ballotpedia. "Asa Hutchinson." Accessed March 12, 2019. https://ballotpedia.org/Asa_Hutchinson

Bureau of Business and Economic Research. "The Economic Impact of Medicaid Expansion in Montana." University of Montana. April 2018. https://mthcf.org/wp-content/uploads/2018/04/BBER-MT-Medicaid-Expansion-Report_4.11.18.pdf

Butterworth, Peter, L S Leach, L Strazdins, S C Olesen, B Rodgers, D H Broom,"The Psychosocial Quality of Work Determines Whether Employment Has Benefits for Mental Health: Results from a Longitudinal National Household Panel Survey," *Occup Environ Med* 68 (2011): 806-812.

Cancian, Maria. "Rhetoric and Reality of Work-Based Welfare Reform." *Social Work*, 46, no. 4 (October 2001): 309-314.

Cantor, Joel C., Frank J. Thompson, and Jennifer Farnham. "States' Commitment to Medicaid before the Affordable Care Act: Trends and Implications." *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, (February 2013), 71–84.

Centers for Medicare and Medicaid. *Medicaid Program; Review and Approval Process for Section 1115 Demonstrations.* 75 FR 56946 (September 17, 2010): 56946-56961. https://www.govinfo.gov/content/pkg/FR-2010-09-17/pdf/2010-23357.pdf

Cheves, John. "Medicaid Recipients File Suit Again to Block Bevin's Work Requirements and Premiums." *Lexington Herald Leader,* January 15, 2019. https://www.kentucky.com/news/politics-government/article224562970.html

Daniels, Norman. "Justice and Access to Health Care." Stanford Encyclopedia of Philosophy. Last modified October 20, 2017. https://plato.stanford.edu/entries/justice-healthcareaccess/

Dickson, Virgil. "CMS Fights Claims that Waiver Process is Corrupt and Opaque." *Modern Healthcare,* July 8, 2015. https://www.modernhealthcare.com/article/20150708/NEWS/150709927/cms-fights-claims-that-waiver-process-is-corrupt-and-opaque

Frean, Molly, Jonathan Gruber, and Benjamin D. Sommers. "Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act." *Journal of Health Economics* 53 (2017): 72-86.

Gains, Patrice. "Welfare Reform: Is It Working?" *The Crisis,* 114, no. 1 (January/February 2007): 14-18.

Goold, Susan D., and Jeffrey Kullgren. "Report on the 2016 Healthy Michigan Voices Enrollee Survey." University of Michigan Institute for Healthcare Policy & Innovation. January 17, 2018. https://www.michigan.gov/documents/mdhhs/2016_Healthy_Michigan_Voices_Enrollee_Survey_-_Report__Appendices_1.17.18_final_618161_7.pdf

Guyer, Jocelyn, Naomi Shine, MaryBeth Musumeci, and Robin Rudowitz. "A Look at the Private Option in Arkansas." Kaiser Family Foundation. August 26, 2015. https://www.kff.org/medicaid/issue-brief/a-look-at-the-private-option-in-arkansas/view/print/

Hardy, Benjamin. "Over 18,000 Lost Coverage in 2018 Due to Medicaid Work Rule, but Only Fraction Have Reapplied." *Arkansas Times*. January 15, 2019. https://www.arktimes.com/ArkansasBlog/archives/2019/01/15/over-18000-lost-coverage-in-2018-due-to-medicaid-work-rule-but-only-fraction-have-reapplied

Hardy, Benjamin, and David Ramsey. "The future of the private option. It could turn on the results of two state Senate races." *Arkansas Times.* October 30, 2014. https://www.arktimes.com/arkansas/the-future-of-the-private-option/Content?oid=3522511

Hardy, Benjamin, and David Ramsey. "The GOP in charge in Arkansas. What will it mean?" *Arkansas Times.* November 13, 2014. https://www.arktimes.com/arkansas/the-gop-in-charge-in-arkansas/Content?oid=3541245

Hardy, Benjamin. "Governor points to declining Medicaid rolls in seeking renewal of Arkansas Works from legislature." Arkansas Times. January 3, 2018. https://www.arktimes.com/arkansas/governor-points-to-declining-medicaid-rolls-in-seeking-renewal-of-arkansas-works-from-legislature/Content?oid=13350200

Hardy, Benjamin. "First, get a job: Arkansas's Medicaid work requirements begin." *Arkansas Times*. June 14, 2018. https://www.arktimes.com/arkansas/first-get-a-job/Content?oid=19088707

Hardy, Benjamin. "Work requirement bars over 4,000 from receiving Medicaid coverage." *Arkansas Times.* September 13, 2018. https://www.arktimes.com/arkansas/work-requirement-bars-over-4000-from-receiving-medicaid-coverage/Content?oid=23041407

Hardy, Benjamin. "Locked out of Medicaid." *Arkansas Times.* November 19, 2018. https://www.arktimes.com/arkansas/when-arkansas-works-doesnt/Content?oid=25890378

Hardy, Benjamin. "Medicaid work requirement grows to include younger beneficiaries." *Arkansas Times.* February 15, 2019. https://www.arktimes.com/ArkansasBlog/archives/2019/02/15/medicaid-work-requirement-grows-to-include-younger-beneficiaries

Hardy, Benjamin. "Scrubbed from the System." *Arkansas Times.* August 9, 2018. https://www.arktimes.com/arkansas/scrubbed-from-the-system/Content?oid=21285998

Hardy, Benjamin. "Trump Administration Defends Arkansas's Medicaid Work Requirement." *Arkansas Times.* December 1, 2018. https://www.arktimes.com/ArkansasBlog/archives/2018/12/01/trump-administration-defends-arkansass-work-requirements-for-medicaid

Haskins, Ron. "TANF At Age 20: Work Still Works." *Journal of Policy Analysis and Management* 00, no. 0, 1–8 (2015). DOI:10.1002/pam.21878

Levit, Katherine R., Gary L. Olin, and Suzanne W. Letsch. "Americans' Health Insurance Coverage, 1980-91." *Health Care Financing Review* 14, no. 1 (Fall 1992): 31-57.

Mackay, Douglas. "Basic Income, Cash Transfers, and Welfare State Paternalism." *The Journal of Political Philosophy* 0, no. 0 (2019): 1-26.

Mead, Lawrence. "Telling the Poor What to Do." *Public Interest,* 132 (Summer, 1998): 97-112.

Moffit, Robert. "Individual Mandate Unconstitutional, Unenforceable." The Heritage Foundation. March 23, 2011. https://www.heritage.org/health-care-reform/commentary/individual-mandate-unconstitutional-unenforceable

Musumeci, MaryBeth, Robin Rudowitz, and Barbara Lyons. "Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees." Kaiser Family Foundation. December 18, 2018. https://www.kff.org/report-section/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees-issue-brief/

National Federation of Independent Business v. Sebelius. 567 U.S. 1, 55 (2012).

Norris, Louise. "Arkansas and the ACA's Medicaid expansion." *Healthinsurance.org*. November 25, 2018. https://www.healthinsurance.org/arkansas-medicaid/

Obasi, Olivia. "The New Work Requirement for Medicaid." *American Bar Association Health eSource*. September 27, 2018. https://www.americanbar.org/groups/health_law/publications/aba_health_esource/2017-2018/june-2018/medicaid/

Oberg, Charles N., and Cynthia Longseth Polich. "Medicaid: Entering the Third Decade." *Health Affairs* 7, no. 4 (Fall 1988). https://doi.org/10.1377/hlthaff.7.4.83

Pavetti, LaDonna. "Work Requirements Don't Cut Poverty, Evidence Shows." Center on Budget and Policy Priorities. Last modified June 7, 2016. https://www.cbpp.org/sites/default/files/atoms/files/6-6-16pov3.pdf

Pew Research Center. "Party affiliation among adults in Arkansas." 2014. https://www.pewforum.org/religious-landscape-study/state/arkansas/party-affiliation/#demographic-information

Piven, Frances Fox. "Welfare and Work." *Social Justice* 25, no. 1 (Spring 1998): 67-81.

Rosenbaum, Sara. "The Supreme Court's Medicaid Ruling: 'A Shift in Kind, Not Merely Degree.'" *Health Affairs Blog.* June 28, 2012. DOI: 10.1377/hblog20120628.020808

Rosenbaum, Sara. "*Stewart v. Azar*: Inside the Briefs Filed by Plaintiffs and their Amici." *Health Affairs Blog.* April 20, 2018. https://www.healthaffairs.org/do/10.1377/hblog20180419.350167/full/

Rosenbaum, Sara. "Medicaid Work Requirements: Inside the Decision Overturning Kentucky HEALTH's Approval." *Health Affairs Blog.* July 2, 2018. https://www.healthaffairs.org/do/10.1377/hblog20180702.144007/full/

Scytl. "Arkansas 2018 General Election and Nonpartisan Judicial Runoff Official Results." Last modified December 3, 2018. https://results.enr.clarityelections.com/AR/92174/Web02-state.216038/#/

Solomon, Judith. "Medicaid Work Requirements Can't Be Fixed: Unintended Consequences Are Inevitable Result." Center on Budget and Policy Priorities. January 10, 2019. https://www.cbpp.org/sites/default/files/atoms/files/1-10-19health.pdf

Mullainathan, Sendhil, and Eldar Shafir. *Scarcity: Why Having Too Little Means So Much.* Allen Lane, 2013.

Thomas E. Price, M.D. and Seema Verma, MPH to Governors. 2017.

U.S. Census Bureau, "Electorate Profile: Arkansas. Selected Characteristics of the Voting-Age Population." 2014. Accessed March 1, 2019. https://www.census.gov/content/dam/Census/library/visualizations/2016/comm/cb16-tps18_graphic_voting_arkansas.jpg

U.S. Government Accountability Office, *MEDICAID DEMONSTRATIONS: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives*, GAO-15-239, April 23, 2015. https://www.gao.gov/products/GAO-15-239

U.S. Government Accountability Office, *MEDICAID DEMONSTRATION WAIVERS: Approval Process Raises Cost Concerns and Lacks Transparency*, GAO-13-384, June 25, 2013. https://www.gao.gov/products/GAO-13-384

U.S. Government Accountability Office, *MEDICAID DEMONSTRATIONS: More Transparency and Accountability for Approved Spending Are Needed,* GAO-15-715T, June 24, 2015. https://www.gao.gov/products/GAO-15-715T

Wilson, J. Craig and Joseph Thompson. "Nation's First Medicaid Work Requirement Sheds Thousands From Rolls In Arkansas." *Health Affairs.* October 2, 2018. https://www.healthaffairs.org/do/10.1377/hblog20181001.233969/full/

Wachino, Vikki. "Medicaid 'work requirements' won't improve health outcomes." *The Hill.* January 18, 2018. https://thehill.com/opinion/healthcare/369569-medicaid-work-requirements-wont-improve-health-outcomes

Wax, Amy. "Something for Nothing: Liberal Justice and Welfare Work Requirements." *Emory Law Journal*. 52, no. 1 (2003): 1-60.

Wu, Chi-Fang. "Severity, Timing, and Duration of Welfare Sanctions and the Economic Well-Being of TANF Families with Children." *Children and Youth Services Review* 30 (2008): 26–44.